COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

MEDALLION II
MANAGED CARE CONTRACT

JULY 1, 2004

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CONTRACT FOR SERVICES

BETWEEN

THE VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

AND

MANAGED CARE CONTRACTOR
(Reflected in Attachment XXIV – MCO Signature Page of this Contract)

The Department of Medical Assistance Services (herein referred to as the "Department"), an agency of the Commonwealth of Virginia, and the Contracted Managed Care Organization (MCO) (herein referred to as the "Contractor"), an organization which makes available to enrolled recipients, in consideration of periodic fixed payments, comprehensive health care services provided by providers selected by the organization who are employees or partners of the organization or who have entered into a referral or contractual (subcontracting) arrangement with the organization, for the purpose of providing and paying for contract services to recipients enrolled in the MCO under the State Plan for Medical Assistance approved by the Commonwealth of Virginia and by the Secretary of the United States Department of Health and Human Services, pursuant to Title XIX of the Social Security Act, in consideration of the mutual covenants, agreements, and promises contained herein, the parties hereto, intending to be legally bound, do herewith agree with the terms outlined in the following Contract.

The Department and Contractor, as defined in section 160.103 of the Final HIPAA Privacy Rule, have entered into this Business Associate Agreement (herein referred to as the "Contract") to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Final Privacy regulation requirements for such an Agreement, as well as our duty to protect the confidentiality and integrity of Protected Health Information (PHI) required by law, Department policy, professional ethics, and accreditation requirements. Parties signing this Agreement shall fully comply with the provisions of the Regulations implementing HIPAA.

ARTICLE I - DEFINITIONS

Accreditation –The process of evaluating an organization against a set number of measures of performance, quality, and outcomes by a recognized industry standard accrediting agency. The accrediting agency certifies compliance with the criteria, assures quality and integrity, and offers purchasers and members a standard of comparison in evaluating health care organizations.

Action – Consistent with 42 CFR §438.400, action refers to the denial of a service authorization request; or the reduction, suspension, or termination of a previously authorized service; denial in whole or in part of a payment for a covered service (except where the provider's claim is denied for technical reasons including but not limited to prior authorization rules, referral rules, late filing, invalid codes, etc); or failure to provide services within the timeframes required in Article II.L and Article II.S of this Contract; or the denial of an enrollee's request to exercise his right under 42 CFR 438.52(b)(2)(ii) (described in Article II.S. of this Contract) to obtain services outside of the network.

Actuarially Sound Capitation Rates – As defined in 42 CFR 438.6 means capitation rates that have been developed in accordance with generally accepted actuarial principles and practices; are appropriate for the populations to be covered and the services to be furnished under the contract; and have been certified as actuarially sound by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

Annually – For the purposes of contract reporting requirements, annually shall be defined as within 90 calendar days of the effective contract date and effective contract renewal date.

Appeal - In accordance with 42 CFR 438.400, an appeal is defined as a request for review of an action, as "action" is defined in this Contract.

Balanced Budget Act – Refers to the Balanced Budget Act (BBA) of 1997; final rule issued June 14, 2002; effective August 13, 2002. The BBA is the comprehensive revision to Federal statutes governing all aspects of Medicaid managed care programs as set forth in section 1932 of the Social Security Act and Title 42 Code of Federal Regulations (CFR) Part 438 et. seq.

Business Days – Means Monday through Friday, 8:30 AM to 5:00 PM, Eastern Standard Time, unless otherwise stated.

Capitation Payment - A payment the Department makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical services under the State Plan, regardless of whether the particular recipient receives services during the period covered by the fee.

Capitation Rate - The monthly rate, payable to the Contractor, per enrollee, for all expenses incurred by the Contractor in the provision of contract services as defined herein.

Case Management – The process of identification of patient needs and the development and implementation of a plan of care to efficiently achieve the optimum quality patient outcomes in the most cost-effective manner.

Centers for Medicare and Medicaid Services (CMS) – (Formerly known as HCFA) The Federal agency of the United States Department of Health and Human Services that is responsible for the administration of Title XIX and Title XXI of the Social Security Act.

Children With Special Health Care Needs (CSHCN) – Children with special needs have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age. These include the children in the eligibility category of SSI participation.

Claim – An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the HCFA 1500, UB-92, and/or ADA Dental claim forms.

Clean Claim - A claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim under this title. See sections 1816(c)(2)(B) and 1842(c)(2)(B) of the Social Security Act.

Client, Recipient, Enrollee, Member or Participant - means an individual having current Medicaid/FAMIS Plus eligibility who shall be authorized by the Department to participate in the Medallion II program.

Cold Call Marketing – Any unsolicited personal contact with a potential enrollee by an employee, affiliated provider or contractor of the entity for the purpose of influencing enrollment with such entity.

Complaint – A grievance.

Consumer Assessment of Health Plans Survey (CAHPS^{TM}) – A consumer satisfaction survey developed collaboratively by Harvard, RAND, the Agency for Health Care Policy and Research, the Research Triangle Institute and Westat that has been adopted as the industry standard by NCQA and CMS to measure the quality of managed care plans.

Contract - This signed and executed document.

Contract Modifications - Any changes or modifications to the Contract that are mutually agreed to in writing by the Contractor and the Department or are mandated by changes in Federal or State laws or regulations.

Contractor - Any entity that contracts with the Department, under the State Plan and in return for a payment, to process claims, to pay for or provide medical services, or to enhance the Department's capability for effective administration of the program.

Cost Sharing – Co-payments paid by the enrollee in order to receive medical services.

Days - Business days, unless otherwise specified.

Department - The Virginia Department of Medical Assistance Services.

Disenrollment - The process of changing enrollment from one Medallion II MCO plan to another MCO or to the Department's Primary Care Case Management (PCCM) program, if applicable.

Drug Efficacy Study Implementation (DESI) – Drugs for which DMAS will not provide reimbursement because the drugs have been determined by the Food and Drug Administration (FDA) to lack substantial evidence of effectiveness.

Early Intervention – As defined in the Virginia Code § 2.2-5300, are those services provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development and provided to children from birth to age three who have (i) a twenty-five percent developmental delay in one or more areas of development, (ii) atypical development, or (iii) a handicapping condition. The Contractor shall cover medically necessary services, including rehabilitative therapies within the amount duration and scope as defined in 12VAC30-130-10 and 12VAC30-50-200. All services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice. This includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) - Those services defined by Federal law in Section 1905(r) of the Social Security Act, 42 USC §1396 d (r), to include screening and diagnostic services to determine physical or mental defects in recipients under age twenty-one (21), and health care, treatment, and all other measures to correct or ameliorate any defects and chronic conditions discovered.

Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in

serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

Emergency Room Assessment Fee (Triage Fee) - The fee paid for all non-emergency claims for services delivered in the emergency room. The fee has two (2) components: a facility component and a physician component. The facility component is reimbursed using an all-inclusive fee that approximates the fee for an intermediate emergency room visit. The physician component is reimbursed using an all-inclusive fee that approximates the fee for a brief physician office visit for a new patient.

Emergency Services - Those health care services that are rendered by participating or non-participating providers, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the client's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or,
3. Serious dysfunction of any bodily organ or part.

Encounter – Any covered or enhanced service received by an Enrollee through the Contractor.

Encryption – A security measure process involving the conversion of data into a format which cannot be interpreted by outside parties.

Enhanced Services - Services offered by the Contractor to enrollees in addition to Medallion II covered services. The Department will not pay for enhanced services.

Enrollee - A person eligible for Medicaid/FAMIS Plus who is enrolled with an MCO Contractor to receive services under the provisions of this Contract.

Enrollee Handbook – Document required by the contract to be provided by the MCO to the enrollee prior to the first day of the month in which their enrollment starts. The handbook must include all of the following sections: table of contents, enrollee eligibility, choosing or changing an MCO, choosing or changing a PCP, making appointments and accessing care, enrollee services, emergency care, enrollee identification cards, enrollee responsibilities, MCO responsibilities, grievances (complaints), and appeals, translation services, and program or site changes.

Enrollment - The completion of approved enrollment forms by or on behalf of an eligible person and assignment of a recipient to an MCO by the Department in accordance with the terms of this Contract.

Enrollment Area - The counties and municipalities in which an eligible organization is authorized by the Commonwealth of Virginia, pursuant to a Contract, to operate as a

Medallion II Contractor and in which service capability exists as defined by the Commonwealth.

Enrollment Broker - An independent broker who enrolls recipients in the Contractor plan and who is responsible for the operation and documentation of a toll-free recipient service helpline. The responsibilities of the enrollment broker include, but are not limited to, recipient education and enrollment, assistance with and tracking of recipient's grievance resolution, and may include recipient marketing and outreach.

Enrollment Period – The time that a recipient is enrolled in a Department approved MCO during which they may not disenroll or change MCOs unless disenrolled under one of the conditions described in Article II and pursuant with Section 1932 (a)(4)(A) of Title XIX. This period may not exceed twelve months.

Evidence of Coverage - Any enrollment package that includes any certificate, individual or group agreement or contract, or identification card or related documents issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which an enrollee is entitled.

Excluded Entity - Any provider or subcontractor that is excluded from participating in the Contractor's health plan as defined in Article II, Section K.6, of this Contract.

Exclusion from Medallion II - The removal of an enrollee from the Medallion II program on a temporary or permanent basis.

Expedited Appeal –The process by which an MCO must respond to an appeal by a recipient if a denial of care decision by an MCO may jeopardize life, health or ability to regain maximum function. The decision must be rendered within three (3) business days of the recipient appeal.

External Quality Review (EQR) – Analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that a MCO or their contractors furnish to Medicaid recipients, as defined in 42 CFR 438.320.

External Quality Review Organization (EQRO) – An organization that meets the competence and independence requirements set forth in 42 CFR 438.354 and performs external quality review, and other EQR related activities as set forth in 42 CFR 438.358.

Family Planning –Those services necessary that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility nor services to promote fertility.

Family Planning Waiver – A Medicaid Research and Demonstration Waiver available to women of child-bearing years (9 to 57 years of age) who received a Virginia Medicaid-reimbursed pregnancy related service on or after October 1, 2002, who is less than 24 months post-partum, who has income less than or equal to 133% of the Federal

Poverty Level, and who has not otherwise been determined eligible for Virginia Medicaid coverage.

FAMIS Plus Recipients – Children under the age of 19 who meet "medically indigent" criteria under Medicaid program rules, and who are assigned an aid category code of 90; 91 (under 6 years of age); 92 and 94. FAMIS Plus children receive the full Medicaid benefit package and have no cost sharing responsibilities. Additionally, for the terms set forth in this Contract, FAMIS Plus and Medicaid enrollees shall be treated in the same manner. Any information sent to FAMIS Plus and Medicaid enrollees must appropriately address the entire intended population. For example, all marketing and benefit materials cannot specify "Medicaid" unless they also specify "FAMIS Plus." If the material does not specify "Medicaid," it does not need to specify "FAMIS Plus."

Federally Qualified Health Centers (FQHCs) - Those facilities as defined in 42 C.F.R. § 405.2401(b), as amended.

Fee-for-Service - The traditional health care payment system in which physicians and other providers receive a payment for each unit of service they provide. This method of reimbursement is not used by the Department to reimburse the Contractor under the terms of this Contract.

Flesch Readability Formula - The formula by which readability of documents is tested as set forth in Rudolf Flesch, *The Art of Readable Writing* (1949, as revised 1974).

Formulary – A list of drugs that the MCO has approved. Prescribing some of the drugs may require prior authorization.

Fraud - Intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit.

Generally Accepted Accounting Principles (GAAP) - Uniform minimum standards of and guidelines to financial accounting and reporting as established by the Financial Accounting Standards Board and the Governmental Accounting Standards Board.

Grievance - In accordance with 42 CFR § 438.400, grievance means an expression of dissatisfaction about any matter other than an "action." Grievance is also used to refer to the overall system that includes grievances and appeals handled at the MCO level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)

Guardian – An adult who is legally responsible for the care and management of a minor child.

Health Insurance Portability & Accountability Act of 1996 (HIPAA) - Title II of HIPAA requires standardization of electronic patient health, administrative and financial data; unique health identifiers for individuals, employers, health plans, and health care providers; and security standards protecting the confidentiality and integrity of individually identifiable health information past, present, or future.

Home and Community-Based Care Services (HCBS) - Medicaid community-based care programs operating in the Commonwealth under the authority of §1915(c) of the Social Security Act, 42 U.S.C. §1396 n (c) including, but not limited to, the waivers for AIDS, Elderly and Disabled (E&D), Consumer Directed Personal Attendant Services (CDPAS), Mental Retardation, Technology Assisted, and Individual and Family Developmental Disabilities Support (DD).

Hospital - A facility that meets the requirements of 42 C.F.R. § 482, as amended.

Informational Materials – Written communications from the Contractor to enrollees that educates and informs enrollees about services, policies, procedures, or programs specifically related to Medicaid/FAMIS Plus.

Initial Implementation - The first time a program or a program change is instituted in a geographical area by the Department.

Inquiry – An oral or written communication usually received by a Member Services Department or telephone help line representative made by or on the behalf of a member that may be: 1) questions regarding the need for additional information about eligibility, benefits, plan requirement or materials received, etc., 2) provision of information regarding a change in the member's status such as address, family composition, etc., or; 3) a request for assistance such as selecting or changing a PCP assignment, obtaining translation or transportation assistance, obtaining access to care, etc. Inquiries are not expressions of dissatisfaction.

Intermediate Care Facility for the Mentally Retarded - Intermediate care facility/mental retardation (IFC/MR) is a facility, licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS), in which care is provided to mentally retarded individuals who are not in need of skilled nursing care, but who need more intensive training and supervision than would be available in a rooming, boarding home, or group home. Such facilities must comply with Title XIX standards, provide health or rehabilitative services, and provide active treatment to clients toward the achievement of a more independent level of functioning.

Laboratory - Any laboratory performing testing for the purpose of providing information for the diagnosis, prevention, or treatment of disease or impairment, or the assessment of the health of human beings, and which meets the requirements of 42 C.F.R. § 493.3, as amended.

Managed Care Organization (MCO) –An entity that meets the participation and solvency criteria defined in 42 CFR Part 438 and has an executed agreement with DMAS to provide services covered under the Medallion II program. Covered services for Medallion II individuals must be accessible (in terms of timeliness, amount, duration, and scope) as compared to other Medicaid recipients served within the area.

Marketing Materials - Any materials that are produced in any medium, by or on behalf of an MCO; are used by the MCO to communicate with individuals who are not its enrollees; and can reasonably be interpreted as intended to influence the individuals to enroll or reenroll in that particular MCO and entity.

Marketing Services - Any communication, services rendered or activities conducted by the Contractor or its subcontractors to its prospective enrollees for the purpose of education or providing information that can reasonably be interpreted as intended to influence the recipient to enroll in that particular MCO's Medicaid/FAMIS Plus product.

Medallion II Carved-Out Services - The subset of Medicaid/FAMIS Plus covered services which the Contractor shall not be responsible for covering under the Medallion II program.

Medallion II Covered Services - The subset of Medicaid/FAMIS Plus covered services which the Contractor shall be responsible for covering under the Medallion II program.

Medicaid/FAMIS Plus Covered Services - Services as defined in the Virginia State Plan for Medical Assistance or State regulations.

Medicaid Fraud Control Unit - The unit established within the Office of the Attorney General to audit and investigate providers of services furnished under the Virginia State Plan for Medical Assistance, as provided for in the Code of Virginia § 32.1-320, as amended.

Medicaid Management Information System (MMIS) - The medical assistance and payment information system of the Virginia Department of Medical Assistance Services.

Medicaid/FAMIS Plus Non-Covered Services - Services not covered by DMAS and, therefore, not included in covered services as defined in the Virginia State Plan for Medical Assistance or State regulations.

Medicaid Recipient - Any individual enrolled in the Virginia Medicaid program.

Medical Necessity - "Medical necessity" or "medically necessary" means appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience. As defined in 42 C.F.R. § 440.230, services must be sufficient in amount, duration and scope to reasonably achieve their purpose.

Monthly – For the purposes of contract reporting requirements, monthly shall be defined as the 15th day of each month for the prior month's reporting period. For example, January's monthly reports are due by February 15th; February's are due by March 15th, etc.

Network Provider - The health care entity or health care professional who is either employed by or has executed an agreement with the Contractor, or its subcontractor, to render covered services, as defined in this Contract, to enrollees.

Newborn Guarantee Coverage Period - The time period between the date of birth of a child whose mother is a Medicaid/FAMIS Plus enrollee with the Contractor until the last day of the third month including the month of birth, unless otherwise specified by the Department. For example, a baby born any day in February will be enrolled with the Contractor until April 30.

Non-participating Provider - A health care entity or health care professional not in the Contractor's participating provider network.

Open Enrollment – Time frame defined by CMS as 60 days prior to the end of the recipient's enrollment. Before this 60-day time frame, recipients must be notified of their ability to disenroll or change plans at the end of their enrollment period.

Out-of-Network Coverage - Coverage provided outside of the established MCO network; medical care rendered to an enrollee by a provider not affiliated with the Contractor or contracted with the Contractor.

Party in Interest - Any director, officer, partner, agent, or employee responsible for management or administration of the Contract; any person who is directly or indirectly the beneficial owner of more than five (5) percent of the equity of the Contractor; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by and valuing more than five (5) percent of the Contractor; or, in the case of a Contractor organized as a nonprofit corporation or other nonprofit organization, an incorporation or enrollee of such corporation under applicable State corporation law. Additionally, any organization in which a person previously described is a director, officer or partner, that has directly or indirectly a beneficial interest of more than five (5) percent of the equity of the Contractor or has a mortgage, deed of trust, note, or other interest valuing more than five (5) percent of the assets of the Contractor; any person directly or indirectly controlling, controlled by, or under common control with the Contractor; or any spouse, child, or parent of a previously described individual.

Person with Ownership or Control Interest - A person or corporation that owns, directly or indirectly, five (5) percent or more of the Contractor's capital or stock or received five (5) percent of the total assets of the Contractor in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the Contractor or by its property or assets, or is an officer, director, or partner of the Contractor.

Post Stabilization Services – Covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

Potential Enrollee – A Medicaid/FAMIS Plus recipient who is subject to mandatory enrollment in a given managed care program. [42CFR438.10(a)]

Previously Authorized – As described in 42 CFR 438.420, in relation to continuation of benefits, previously authorized means a prior approved course of treatment, and is best clarified by the following example. If the Contractor authorizes 20 visits and then later reduces this authorization to 10 visits, this exemplifies a "previously authorized service" that is being reduced. Conversely, "previously authorized" does not include the example whereby (1) the MCO authorizes 10 visits; (2) the 10 visits are rendered; and (3) another 10 visits are requested but are denied by the MCO. In this case, the fact that the Contractor had authorized 10 visits on a prior request for authorization is not germane to continuation of benefits requirements for previously authorized services that are terminated, suspended or reduced.

Primary Care Case Management (PCCM) - A system under which a primary care case manager contracts with the Commonwealth to furnish case management services (which include the location, coordination, and monitoring of primary health care services) to recipients.

Primary Care Provider (PCP) - A practitioner who provides preventive and primary medical care for eligible recipients and who certifies prior authorizations and referrals for all medically necessary specialty services. PCPs may include pediatricians, family and general practitioners, internists, obstetrician/gynecologists, and specialists who perform primary care functions such as surgeons, clinics including, but not limited to, health departments, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), etc.

Protected Health Information (PHI) - Individually identifiable information, including demographics, which relates to a person's health, health care, or payment for health care. HIPAA protects individually identifiable health information transmitted or maintained in any form or medium.

Quarterly – For the purposes of contract reporting requirements, quarterly shall be defined as within 30 calendar days after the end of each quarter.

Quarters - Calendar quarters starting on January 1, April 1, July 1, and October 1.

Rural Area - A census designated area outside of a metropolitan statistical area.

Rural Health Clinic - A facility as defined in 42 C.F.R. § 491.2, as amended.

School Health Services- School health services are defined as physical therapy, occupational therapy, speech therapy, nursing, school health assistant, psychiatric and psychological services rendered to children who qualify for these services under the federal Individuals with Disabilities Education Act (20 USC §1471 et seq.) by (i) employees of the school divisions or (ii) providers that subcontract with school divisions, as described in 12 VAC 30-50-229.1.

School health services are carved out of the contract and are reimbursed directly by DMAS. In order to receive DMAS reimbursement for school health services:

1. Services must meet DMAS' medical necessity criteria.
2. The school division must be enrolled with DMAS as a provider.
3. Claims for all school health services must be billed to DMAS by the school division using the school division's Medicaid provider number. These school health services include those services provided by either the school division and/or provided by the school division's contractor(s).
4. DMAS will not directly reimburse contractors of school divisions for school health services. DMAS considers the school division responsible for payments to providers with whom the school division negotiates contracts.

Service Authorization Request – A managed care enrollee's request for the provision of a service.

State Fair Hearing – The Department's evidentiary hearing process. Any "action" or appeal decision rendered by the MCO may be appealed by the enrollee to the DMAS Client Appeals Division. The Department conducts evidentiary hearings in accordance with regulations at 42 CFR § 431.200 through 431.250 and 12 VAC30-110-10 through 12VAC30-110-380.

State Plan for Medical Assistance (State Plan) - The comprehensive written statement submitted to CMS by the Department describing the nature and scope of the Virginia Medicaid program and giving assurance that it will be administered in conformity with the requirements, standards, procedures and conditions for obtaining Federal financial participation. The Department has the authority to administer the State Plan for Virginia under Code of Virginia § 32.1-325, as amended.

Subcontract - A written contract between the Contractor and a third party, under which the third party performs any one or more of the Contractor's obligations or functional responsibilities under this Contract.

Subcontractor - A State approved entity that contracts with the Contractor to perform part of the Contractor's responsibilities under this Contract. For the purposes of this Contract, the subcontractor's providers shall also be considered providers of the Contractor.

Successor Law or Regulation - That section of Federal or State law or regulation which replaces any specific law or regulation cited in this Contract. The successor law or regulation shall be that same law or regulation if changes in numbering occur and no other changes occur to the appropriate cite. In the event that any law or regulation cited in this Contract is amended, changed or repealed, the applicable successor law or regulation shall be determined and applied by the Department in its sole discretion. The Department may apply any source of law to succeed any other source of law. The Department shall provide the Contractor written notification of determination of successor law or regulation.

Temporary Detention Order (TDO) - An emergency custody order by sworn petition to any magistrate to take into custody a person believed to be mentally ill and in need of hospitalization and transported to a location to be evaluated pursuant to 42 C.F.R. 441.150 and Code of Virginia, 16.1- 335 et. seq. and 37.1-67.1 et seq.

Third-Party Liability - Any entity (including other government programs or insurance) which is or may be liable to pay all or part of the medical cost for injury, disease, or disability of an applicant or recipient of Medicaid.

Urban Area - Places of 2,500 or more persons incorporated as cities, villages, boroughs, and towns but excluding the rural portions of "extended cities" according to the US Department of Commerce, Bureau of the Census.

Urgent Medical Condition - A medical (physical, mental or dental) condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four (24) hours could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

a) Placing the patient's health in serious jeopardy;
b) Serious impairment to bodily function;
c) Serious dysfunction of any bodily organ or part; or
d) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Utilization Management – The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.

Value-Added Network (VAN) - A third party entity (e.g. vendor) that provides hardware and/or software communication services, which meet the security standards of telecommunication.

ARTICLE II - FUNCTIONS AND DUTIES OF CONTRACTOR

A. REQUIREMENTS TO CONDUCT BUSINESS

1. Statutory State Licensing Requirements

The Contractor shall retain at all times during the period of this Contract a valid license issued by the State Corporation Commission and comply with all terms and conditions set forth in the Code of Virginia §§ 38.2-4300 through 38.2-4323, 14 VAC 5-210-10 et. seq., and any and all other applicable laws of the Commonwealth of Virginia, as amended.

2. Licensure Across State Boundaries

A Contractor licensed in Virginia may include in its provider network providers which are located across State boundaries, as long as all such providers are enrolled in Virginia Medicaid and are necessary for the delivery of services to enrollees in a particular locality. The Contractor may also utilize non-participating out-of-state providers who are not enrolled as Virginia Medicaid providers.

3. Accreditation Requirements

The Contractor must demonstrate its ability to retain accreditation by the National Committee for Quality Assurance (NCQA). If not accredited by the NCQA, the Contractor must seek NCQA accreditation within six months after the start of this Contract, or thirty (30) calendar days after becoming eligible to seek NCQA accreditation, whichever is later. The Contractor must report to the Department any deficiencies noted within the previous year by NCQA within thirty (30) calendar days of being notified of the deficiencies, or on the earliest date permitted by NCQA. Denial of NCQA accreditation status may be cause for the Department to impose remedies or sanctions to include suspension, depending upon the reasons for denial by NCQA.

The Department will recognize and accept accreditation from an organization other than NCQA if the participating MCO had applied or received that accreditation at the time of the effective date of this Contract. After that date, any request to have the Department consider accreditation by another agency other than NCQA will be denied.

4. Financial Statements

a. The Contractor shall submit to the Department a copy of all quarterly and annual filings submitted to the Bureau of Insurance. A copy of such filing shall be submitted to the Department on the same day on which it is submitted to the Bureau of Insurance.

Any revisions to a quarterly and/or annual BOI financial statement shall be submitted to the Department on the same day on which it is submitted to the BOI.

b. The Contractor shall agree to work with the Finance Division of the Department to develop a financial report that details medical expenditure categories, total enrollee months related to the expenditures, Incurred But Not Paid (IBNP) amounts, and all administrative expenses associated with the Medallion II program. The Department reserves the right to approve the final format of the report. (Attachment I details the required data elements and shows a draft format for the report.) The report shall be submitted on a semiannual basis to the Department. The first semiannual reporting period shall begin on July 1 and end on December 31. This report is subject to audit and verification by the Department.

5. Financial Records

Throughout the duration of the Contract term, the Contractor shall operate and maintain an accounting system that either (1) meets Generally Accepted Accounting Principles (GAAP) as established by the Financial Accounting Standards Board or (2) can be reconciled to meet GAAP. This accounting system shall have the capability to produce standard financial reports and ad hoc financial reports related to financial transactions and ongoing business activities, and the Contractor shall enhance or update it upon request. Prior to Contract signature, the Contractor must notify the Department about the basis of accounting the Contractor will be using. Throughout the term of the Contract, the Contractor must notify the Department prior to making any changes to its basis of accounting.

6. Financial Solvency Information

The Bureau of Insurance of the Virginia State Corporation Commission regulates the financial stability of all licensed MCOs in Virginia. The Contractor agrees to comply with all Bureau of Insurance standards.

7. Changes in Reserves

The Contractor shall report to the Department within two (2) business days of any sanctions or changes in reserve requirements imposed by the Bureau of Insurance or any other entity.

8. Business Transactions Reporting

The Contractor shall comply with § 1318 of the Health Maintenance Organization Act (42 U.S.C. § 300e, et seq.), as amended, which requires the disclosure and

justification of certain transactions between the Contractor and any related party, referred to as a Party in Interest. Transactions reported under 42 U.S.C. § 300e, et seq., as amended, must be justified as to their reasonableness and potential adverse impact on fiscal soundness.

The Contractor shall notify the Department within five (5) calendar days of any publicly announced acquisition agreement, pre-merger agreement, or pre-sale agreement impacting the Contractor's ownership. Business transactions to be disclosed include, but are not limited to:

a. Any sale, exchange, or lease of any property between the Contractor and a Party in Interest;

b. Any lending of money or other extension of credit between the Contractor and a Party in Interest; and

c. Any furnishing for consideration of goods, services (including management services) or facilities between the Contractor and a Party in Interest. Business transactions for purposes of this section do not include salaries paid to employees for services provided in the normal course of employment by the Contractor.

The information provided for transactions between the Contractor and a Party in Interest will include the following:

a. The name of the Party in Interest in each transaction;

b. A description of each transaction and, if applicable, the quantity of units involved;

c. The accrued dollar value of each transaction during the calendar year; and

d. A justification of the reasonableness of each transaction.

At least five (5) calendar days prior to any change in ownership, the Contractor must provide to the Department information concerning each Person with Ownership or Control Interest as defined in this Contract. This information includes but is not limited to the following:

a. Name, address, and official position;

b. A biographical summary;

c. A statement as to whether the person with ownership or control interest is related to any other person with ownership or control interest such as a spouse, parent, child, or sibling.

d. The name of any organization in which the person with ownership or control interest in the Contractor also has an ownership or control interest, to the extent obtainable from the other organization by the Contractor through reasonable written request. The Contractor must keep copies of all written requests and responses and provide them to the Department when requested; and

e. The identity of any person, principal, agent, managing employee, or key provider of health care services who (1) has been convicted of a criminal offense related to that individual's or entity's involvement in any program under Medicaid or Medicare since the inception of those programs (1965) or (2) has been excluded from the Medicare and Medicaid programs for any reason. This disclosure must be in compliance with § 1128, as amended, of the Social Security Act, 42 U.S.C. §1320a-7, as amended, and 42 C.F.R. § 455.106, as amended, and must be submitted on behalf of the Contractor and any subcontractor as well as any provider of health care services or supplies.

Federal regulations contained in 42 C.F.R. § 455.104 and 42 C.F.R. § 455.106 also require disclosure of all entities with which a Medicaid provider has an ownership or control relationship. The Contractor shall provide information concerning each Person with Ownership or Control.

9. Conflict of Interest Safeguards

In accordance with 1932(d)(3) of the Social Security Act, the Contractor shall comply with conflict of interest safeguards with respect to officers and employees of the Department having responsibilities relating to this Contract. Such safeguards shall be at least as effective as described in the Federal Procurement Policy Act (41 U.S.C. section 27) against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

10. Changes in Key Staff Positions

To promote continual effective communications, the Contractor must notify the Department of changes in key staff positions, particularly the Contract Administrator, Chief Financial Officer, Medical Director, Case Management staff, Member Services/Operations Manager, and Information Technology staff within fifteen (15) calendar days of any change. These changes are to be reported when individuals either leave or are added to these key positions.

11. Medical Management

The contractor shall provide local medical management through licensed registered nurses (RNs) or individuals with appropriate professional clinical expertise to perform case management activities for the Contractor's Medallion II/FAMIS Plus enrollees. The Contractor shall have a full-time, Virginia-based medical director who is a licensed medical doctor. Medical management staffing shall be at a level that is sufficient to perform all necessary medical assessments and to meet all Medallion II/FAMIS Plus enrollees' case management needs at all times.

B. SUBCONTRACTOR MANAGEMENT AND MONITORING

The Contractor may enter into subcontracts for the provision or administration of any or all Medallion II covered services or enhanced services. Subcontracting does not relieve the Contractor of its responsibilities to the Department or enrollees under this Contract. The Department shall hold the Contractor accountable for all actions of the subcontractor and its providers. Additionally, for the purposes of this Contract, the subcontractor's providers shall also be considered providers of the Contractor.

1. Delegation and Monitoring Requirements

In accordance with 42 CFR §438.230, all subcontracts entered into pursuant to this Contract shall meet the following delegation and monitoring requirements.

a. Delegation Requirements

i. All subcontracts shall be in writing;

ii. Subcontracts shall fulfill the requirements of this Contract and applicable Federal and State laws and regulations;

iii. Subcontracts shall specify the activities and reporting responsibilities delegated to the subcontractor; and,

iv. Subcontracts shall provide provisions for revoking delegation or imposing sanctions in the event that the subcontractor's performance is inadequate.

b. Monitoring Requirements

i. The Contractor shall perform on-going monitoring of all subcontractors.

ii. The Contractor shall perform a formal review of all subcontractors at least annually.

iii. As a result of monitoring activities conducted by the Contractor (through on-going monitoring and/or annual review), the Contractor shall identify to the subcontractor deficiencies or areas for improvement, and shall require the subcontractor to take appropriate corrective action.

2. HIPAA Requirements

To the extent that the Contractor uses one or more subcontractors or agents to provide services under this Contract, and such subcontractors or agents receive or have access to protected health information (PHI), each such subcontractor or agent shall sign an agreement with the Contractor that complies with HIPAA.

The Contractor shall ensure that any agents and subcontractors to whom it provides PHI received from the Department (or created or received by the Contractor on behalf of the Department) agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor in this Contract. The Department shall have the option to review and approve all such written agreements between the Contractor and its agents and subcontractors prior to their effectiveness.

3. Department Review Requirements

All subcontracts must ensure the level and quality of care required under this Contract. Subcontracts with the Contractor for delegated administrative and medical services in the areas of planning, finance, reporting systems, administration, quality assessment, credentialing/ recredentialing, utilization management, enrollee services, claims processing, or provider services must be submitted to the Department at least thirty (30) calendar days prior to their effective date. This includes subcontracts for transportation, dental, vision, mental health, prescription drugs, or other providers of service.

All subcontracts are subject to the Department's written approval. The Department may revoke such approval if the Department determines that the subcontractors fail to meet the requirements of this Contract. Subcontracts which require the subcontractor to be responsible for the provision of Medallion II covered services must include the terms set forth in Attachment V, and, for the purposes of this Contract, that subcontractor shall be considered both a subcontractor and network provider. Subcontracts will be considered approved if the Department has not responded within thirty (30) calendar days of the date of Departmental receipt of the request.

The Contractor shall require all subcontractors to submit to the Department, for review and approval, all mass-generated letters intended for provider and/or

enrollee distribution, 30 days prior to their planned distribution. This does not include materials for wellness or business purposes but does extend to letters to generate provider enrollment or advising enrollees of enrollment/disenrollment or other Department functions. The Department shall review and return these documents with any recommended changes within three (3) business days. (Note: this turnaround time does not apply to mailings related to preassignment, review of EOC booklets, contractor marketing materials, or other mailings whose review process is identified elsewhere in this contract.)

C. MARKETING MATERIALS AND SERVICES

For the purposes of this Contract, "Marketing Materials and Services" activities as defined shall apply to enrollees who are not currently enrolled with the Contractor. All Contractors are encouraged to utilize subcontractors for marketing purposes; however, Contractors will be held responsible by the Department for the marketing activities and actions of subcontractors who market on their behalf.

1. Marketing Services

The Contractor shall:

a. Offer its plan to enrollees and provide to those interested in enrolling adequate, written descriptions of the MCO's rules, procedures, benefits, fees and other charges, services, and other information necessary for enrollees to make an informed decision about enrollment.

b. Submit to the Department for prior written approval a complete marketing plan annually.

c. Submit all new and/or revised marketing and informational materials to the Department before their planned distribution. The Department will approve, deny, or ask for modifications to the materials within thirty (30) days of the date of receipt by the Department.

d. Distribute marketing materials to the entire Medallion II eligible population on a city or countywide basis. The Department must approve a request for a smaller distribution area.

e. Coordinate and submit to the Department all of its schedules, plans, and informational materials for community education and outreach programs. The schedule shall be submitted to the Department as soon as possible.

f. All marketing and informational materials shall set forth the Flesch readability scores and certify compliance therewith.

g. The Contractor shall be subject to a fine or other sanctions if it conducts any marketing activity that is not approved in writing by the Department.

2. Allowable MCO Marketing Activities

The Contractor may engage in the following promotional activities:

a. Notify the general public of the Medicaid/FAMIS Plus Managed Care open enrollment period in an appropriate manner through appropriate media, throughout its enrollment area.

b. Distribution through the Department or its agents and posting of written promotional materials pre-approved by the Department.

c. Pre-approved mail campaigns through the Department or its agents to regions of potential enrollees and pre-approved informational materials for television, radio, and newspaper dissemination.

d. Fulfillment of potential enrollee requests to the MCO for general information, brochures, and/or provider directories that will be mailed to the enrollee.

e. Marketing at community sites or other approved locations, excluding Department of Social Services (DSS) eligibility offices and provider offices.

f. Hosting or participating in health awareness events, community events, and health fairs pre-approved by the Department. Representatives from the Department, the enrollment broker and/or local health departments may be present. The Contractor must make available informational material that includes the enrollment comparison chart. The Contractor may not use the event to generate a list of non-enrolled enrollees. The Contractor is allowed to collect names and telephone numbers for marketing purposes; however, no Medicaid/FAMIS Plus ID numbers may be collected at the event. DMAS will supply copies of benefit charts upon proper notification.

g. Health screenings may be offered by the Contractor at community events, health awareness events, and in wellness vans. The Contractor shall ensure that every enrollee receiving a screening is instructed to contact his or her PCP if medical follow-up is indicated and that the enrollee receives a printed summary of the assessment information to take to his or her PCP. The Contractor is encouraged to contact the enrollee's PCP directly to ensure that the screening information is communicated.

h. Offers of free non-cash promotional items and "give-aways" that do not exceed a total combined nominal value of $10 to any enrollee or family for marketing purposes. Such items must be offered to all Medallion II eligibles for marketing purposes whether or not the enrollee chooses to enroll in the Contractor's plan. The Contractor is encouraged to use items that promote good health behavior, e.g., toothbrushes or immunization schedules.

i. The Contractor is allowed to offer incentives to their enrolled members for the purposes of retaining membership, and/or rewarding for compliance in immunizations, prenatal visits, etc. These incentives shall not be limited in amount as stated in item "h." above. This incentive shall not be extended to any Medicaid/FAMIS Plus individual not yet enrolled in the Contractor's plan. The Contractor must submit all incentive award packages to DMAS for approval prior to implementation.

3. Prohibited Marketing and Outreach Activities

The following are prohibited marketing and outreach activities targeting prospective Medicaid/FAMIS Plus enrollees under this Contract:

a. Engaging in any informational or marketing activities which could mislead, confuse, or defraud enrollees or misrepresent the Department.

b. Directly or indirectly, conducting door-to-door, telephonic, or other "cold call" marketing of enrollment at residences and provider sites.

c. Direct mailing. All mailings must be processed through the Department or its agent.

d. Making home visits for marketing or enrollment activities.

e. Offering financial incentive, reward, gift, or opportunity to eligible enrollees as an inducement to enroll in the Contractor's plan other than to offer the health care benefits from the Contractor pursuant to their contract or as permitted above.

f. Continuous, periodic marketing activities to the same prospective enrollee, e.g., monthly or quarterly give-aways, as an inducement to enroll.

g. Using the DMAS eligibility database to identify and market its plan to prospective Medicaid/FAMIS Plus enrollees or any other

violation of confidentiality involving sharing or selling enrollee lists or lists of eligibles with any other person or organization for any purpose other than the performance of the Contractor's obligations under this Contract.

h. Engaging in marketing activities which target prospective enrollees on the basis of health status or future need for health care services, or which otherwise may discriminate against individuals eligible for health care services.

i. Contacting enrollees who disenroll from the plan by choice after the effective disenrollment date except as required by this Contract or as part of a Department approved survey to determine reasons for disenrollment.

j. Engaging in marketing activities which offer potential enrollees a rebate or a discount in conjunction with the sale of any other insurance, or other benefit, as a means of influencing enrollment or as an inducement for giving the Contractor the names of prospective enrollees.

k. No enrollment related activities may be conducted at any marketing, community, or other event unless such activity is conducted under the direct on-site supervision of the Department or its enrollment broker.

l. No educational or enrollment related activities may be conducted at Department of Social Services offices unless authorized in advance by the Department of Medical Assistance Services.

m. No assertion or statement (whether written or oral) that the Contractor is endorsed by the Center for Medicare and Medicaid Services (CMS); Federal or State government; or similar entity.

D. ELIGIBILITY AND ENROLLMENT

(NOTE: SEE ARTICLE II(a) FOR FUNCTIONS AND DUTIES OF THE CONTRACTOR IN AREAS WHERE MEDALLION II IS OPERATING WITH ONLY ONE (1) CONTRACTED MANAGED CARE ORGANIZATION)

In conducting any enrollment-related activities permitted by this Contract or otherwise approved by the Department, the Contractor shall assure that enrollee enrollment is voluntary and without regard to health status, physical or mental condition or handicap, age, sex, national origin, race, or creed. Individuals shall be enrolled in the order that the enrollees apply to the Enrollment Broker, up to the limits (if any) specified in this Contract. The Contractor shall notify the enrollee of his or her enrollment in the Contractor's plan through a letter submitted simultaneously with the enrollee handbook.

1. Medicaid/FAMIS Plus Eligible Individuals Excluded from Medallion II Participation

The Contractor shall cover all Medicaid/FAMIS Plus eligible individuals, with the exception of individuals excluded from Medallion II, as defined in 12 VAC 30-120-370 B. The Department shall exclude individuals who meet at least one of the exclusion criteria listed below.

a. Individuals who are inpatients in State mental hospitals including but not limited to those listed below:

i. Western State Hospital,
ii. Southwestern VA Mental Health Institution,
iii. Eastern State Hospital,
iv. HW Davis Medical Center,
v. Southern Virginia Mental Health Institution,
vi. Western State HM&S,
vii. Northern Virginia Mental Health Institution,
viii. The Commonwealth Center for Children and Adolescents (formerly known as the Dejarnette Center),
ix. Central State Hospital,
x. Southwestern State HM&S,
xi. Catawba Hospital, and
xii. Piedmont Geriatric Hospital

b. Individuals who are approved by the Department as inpatients in long-stay hospitals, nursing facilities, or intermediate care facilities for the mentally retarded;

c. Individuals who are placed on spend-down;

d. Individuals who are participating in Federal waiver programs for home and community-based and family planning Medicaid coverage;

e. Individuals who are participating in foster care or subsidized adoption programs;

f. Individuals, other than students, who permanently live outside their area of residence for greater than sixty (60) consecutive days, except those individuals placed there for medically necessary services funded by the Contractor or other Medallion II plan;

g. Individuals who receive hospice services in accordance with Department criteria;

h. Individuals with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any insurance purchased through the Health Insurance Premium Payment Program, except as set forth in this Contract;

i. Newly eligible Medallion II enrollees who are in their third trimester of pregnancy and who request exclusion by the 15th of the month in which their enrollment becomes effective. Exclusion may be granted only if the member's obstetrical provider (physician or hospital) does not participate with any of the state-contracted MCOs. Exclusion requests under this paragraph shall be made by the enrollee, MCO, or obstetrical provider.

j. Individuals under age 21 who are enrolled in DMAS authorized Treatment Foster Care (TFC) or Residential Treatment Facility (RTF) programs.

k. Individuals who have been pre-assigned to the Contractor but have not yet been enrolled, who have been diagnosed with a terminal condition and whose physician certifies a life expectancy of six (6) months or less may request exclusion from Medallion II. Requests must be made during the pre-assignment period.

l. Individuals who are inpatients in hospitals, other than those listed in D.2.a of this subsection, at the scheduled time of enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge. (Also reference Article II.D.14 – Delay of Enrollment due to Hospitalization).

m. Certain individuals between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 USC § 1471 et seq.) who are granted an exception by the Department. 12 VAC 30-120-370 B.

The Department shall have sole authority and responsibility for excluding individuals from Medallion II, including those individuals meeting criteria a. through m., above. The Contractor shall promptly notify the Department upon learning that an enrollee meets one or more of these exclusion criteria.

The Department shall, upon new State or Federal regulations or Department policy, exclude other individuals as appropriate.

2. Enrollment of Newborns

Any newborn whose mother is a Medicaid/FAMIS Plus enrollee enrolled in the Contractor's plan on his or her date of birth shall be deemed an enrollee of that plan for at least three months. The newborn's continued enrollment with the Contractor is not contingent upon the mother's enrollment. Additionally, if this Contract is terminated in whole or in part by the Contractor, (i.e., the MCO where the newborn's Mother is enrolled on the newborn's date of birth), the Contractor shall continue newborn coverage until the newborn receives a Medicaid number (and is disenrolled in the Department's MMIS at the next monthly cycle), or for the birth month plus 2 month timeframe, whichever is earlier.

To remain an enrollee of the Contractor's plan, the infant must be identified through established enrollment procedures. The Contractor shall have written policies and procedures governing the identification of newborns by their network providers. The Contractor must make a good faith effort to complete and send the DMAS Form 213-MCO for Newborns (Attachment IV details required field information) to the local DSS. The Contractor is responsible for advising the Department monthly of all newborns that do not receive an identification number within 60 days. The Contractor is responsible for advising the mother/guardian of the newborn that Medicaid/FAMIS Plus ensures continuous eligibility for the child up to 12 months following birth; however, to receive coverage, the local DSS office must be notified of the birth. Additionally, the Contractor is responsible for advising the Department quarterly of all live birth outcomes via electronic report using the format reflected in Attachment IX.

Infants born to mothers enrolled with Medicaid/FAMIS Plus who do not receive a Medicaid/FAMIS Plus identification number prior to the end of the third month will be enrolled in managed care through the preassignment process upon receiving a Medicaid/FAMIS Plus identification number.

3. Preassignment to MCOs

Clients will be preassigned to MCOs through system algorithm, congruent with State conflict of interest safeguards described in 1932(d)(3) of the Social Security Act, based upon the client's history with a contracted MCO as follows:

a. All eligible persons, except those meeting one of the exclusions of Article II, D., 2 shall be enrolled in Medallion II.

b. Once individuals are enrolled in Medicaid/FAMIS Plus, they will receive a letter indicating that they may select one of the contracted MCOs. These letters shall indicate an MCO in which the enrollee will be enrolled if he/she does not make a selection within a designated time period. Enrollees are encouraged to exercise their choice and to select an MCO.

c. Temporary Exception to Medallion II Enrollment

(1) Enrollees under age 21 will be eligible for temporary exception in Medallion II enrollment upon DMAS authorized participation in the following programs:
(a) Treatment Foster Care Case Management
(b) Residential Treatment Services

d. Clients who do not select an MCO shall be assigned to an MCO as follows:

(1) Clients that have a previous enrollment history with a currently contracted MCO will be preassigned to that MCO.

(2) Clients not preassigned pursuant to subsection 1 above will be preassigned to the MCO of another family member, if applicable.

(3) All other clients will be randomly preassigned to an MCO on a basis of approximately equal numbers by MCO in each locality.

(4) Pursuant to 1932 (a)(4), the enrollee can choose to change from the MCO to which they were preassigned during the first 90 days of enrollment.

4. Open Enrollment

Clients will be notified of their ability to change plans at the end of their enrollment period at least sixty (60) days before the end of that period. Enrollment selections will be effective no later than the first day of the second month following the month in which the enrollee makes the request for the change in plans. MCOs that have contractual enrollment limits shall be able to retain existing enrollees who select them and shall be able to participate in open enrollment until contractual limits are met. See attachment XVIII for current open enrollment information by region and city/county.

5. Enrollment Period

Following their initial enrollment into an MCO, Medallion II enrollees shall be restricted to that MCO until the next open enrollment period, unless disenrolled under one of the conditions described in Article II and pursuant with Section 1932 (a)(4)(A) of Title XIX.

For the initial ninety (90) calendar days following the effective date of enrollment, the enrollee will be permitted to disenroll from one MCO to another without cause. This ninety- (90) day time frame during which a client may disenroll without cause applies to the client's initial period of enrollment and to any subsequent enrollment periods when they enroll in a new MCO.

If the enrollee does not disenroll during the ninety- (90) day period, he/she may not disenroll without good cause for the remainder of the enrollment period.

In addition, within sixty (60) days prior to the end of the enrollment period, the Department will inform the enrollee of the opportunity to remain with the current MCO or change to another MCO without cause. Those enrollees who do not choose a new MCO within sixty (60) days prior to the end of the enrollment period shall remain in his or her current MCO.

The enrollee may disenroll from any MCO to another at any time, for good cause, as defined by the Department.

6. Disenrollment

a. Voluntary Disenrollment

All enrollees shall have the right to disenroll from the Contractor's plan to another Plan pursuant to 42CFR438.56, as amended, or § 1903 (m)(2) A of the Social Security Act, as amended, unless otherwise limited by an approved CMS waiver of applicable requirements. During the first ninety (90) calendar days following the effective date of enrollment, an enrollee may disenroll for any reason. A voluntary disenrollment shall be effective no later than the first day of the second month after the month in which the enrollee requests disenrollment.

Consistent with § 1932(A)(4) of the Social Security Act, as amended (42 U.S.C. §1396u-2), the Department must permit an enrollee to disenroll at any time for good cause. The request may be submitted orally or in writing to the Department and cite the reason(s) why he or she wishes to disenroll such as poor quality care, lack of access to necessary providers for services covered under the State Plan, or other reasons satisfactory to the Department. The Department will review the request in accordance with cause for disenrollment criteria defined in 42 CFR 438.56(d)(2) and 12VAC30-120-370.H. The Department will respond to "good cause" requests, in writing, within 15 business days of the Department's receipt of the request. In accordance with 42 CFR §438.56(e)(2), if the Department fails to make a determination by the first day of the second month following the month in which the enrollee files the request, the disenrollment request shall be considered approved and effective on the date of approval.

Upon disenrollment the Contractor is encouraged to send each enrollee a disenrollment letter with the effective date of disenrollment. Upon receipt of an inquiry, the Contractor should provide instructions for the disenrolled enrollee to contact the Department of Social Services (DSS) with any questions regarding Medicaid/FAMIS Plus eligibility. With respect to the disenrollment of newborns, the Contractor should inform mother/parent/guardian that in order to continue the newborn's eligibility, the mother/parent/guardian must go to DSS to obtain a Medicaid/FAMIS Plus identification number for the newborn.

b. Loss of Eligibility for Medallion II due to Status Change

The enrollee will lose eligibility for Medallion II upon occurrence of any of the following events:

i. Death of the enrollee;

ii. Cessation of Medicaid/FAMIS Plus eligibility;

iii. Individuals that meet at least one of the exclusion criteria listed in subsection D.2. of this Contract. The Department shall determine if the individual meets the criteria for exclusion;

iv. Transfer to a Medicaid/FAMIS Plus eligibility category not included in this Contract; or

v. Certain changes made within the Medicaid Management Information System by eligibility case workers at the Department of Social Services.

The Department will determine the need for status change disenrollment based on input and supporting documentation from the Contractor and/or other source(s).

The Contractor shall not be liable for the payment of any services covered under this Contract rendered to an enrollee after the effective date of the enrollee's exclusion or loss of Medallion II eligibility. However, in cases where disenrollment is anticipated, secondary to the recipient's participation in a home and community based care waiver, nursing facility, hospice, or other exclusionary program, the Contractor is responsible for the provision of all services covered under this contract until notified of the disenrollment by the Department.

In certain instances an individual may be excluded from Medallion II participation effective with retroactive dates of coverage. In these cases the recipient's enrollment with the Contractor is ended retroactively. The

Contractor is not liable for services rendered outside of the recipient's dates of enrollment with the Contractor. Providers may submit claims to the Department for services rendered during this retroactive period. Reimbursement by the Department for services rendered during this retroactive period is contingent upon the recipient's meeting eligibility and coverage criteria requirements.

The Contractor shall be entitled to a capitation payment for the enrollee based on the recoupment/reconciliation procedures in Article IV, C. The Contractor shall not be entitled to payment during any month subsequent to status change determination. Capitation payments already paid by the Department for months beyond the month in which the event occurred shall be repaid to the Department in accordance with the provisions of this Contract.

c. Contractor Transfer of Information Upon Enrollee Disenrollment or Exclusion

In accordance with 42 C.F.R. § 434.53, as amended, the Contractor will assist the Department in collecting data regarding reasons for enrollment and disenrollment in the Contractor's managed care plan.

The Department will share with the Contractor data that its agents have regarding reasons for enrollment and disenrollment (via the *Plan Change Report*) at least on a monthly basis.

When an enrollee for whom services have been authorized but not provided as of the effective date of exclusion or disenrollment is excluded or disenrolled from the Contractor's plan and from Medallion II, the Contractor shall provide to the Department or the relevant PCP the history for that enrollee upon request. This prior authorization history shall be provided to the Department or the relevant PCP within five (5) business days of request.

7. Automatic Assignment

The Contractor will accept automatic assignment for any Medallion II eligible enrollee.

8. Automatic Re-Enrollment

Enrollees who have been previously enrolled with the Contractor who regain eligibility for Medallion II enrollment within sixty (60) calendar days of the effective date of exclusion or disenrollment and who do not select another MCO will be reassigned to the Contractor, as appropriate, (provided sufficient enrollee slots are available under this Contract) and without going through the selection or pre-assignment process.

9. Enrollment Effective Time

All enrollments are effective 12:00 A.M. on the first day of the first month in which they appear on the enrollment report, except for newborns, whose coverage begins at birth.

All disenrollments are effective 11:59 P. M. on the last day of enrollment. If the disenrollment is the result of a plan change, it is effective the last day of the month. If the disenrollment is the result of any exclusion, it may be effective any day during the month.

10. PCP Notification of Enrollee Panel

The Contractor must have in place policies and procedures that are acceptable to the Department for notifying PCPs of their panel composition within five (5) business days of the date on which the MCO receives the enrollment report from the Department.

11. Enrollment Verification

The Contractor must have in place policies and procedures to ensure that in-and out-of-network providers can verify enrollment in the Contractor's plan prior to treating a patient for non-emergency services. The Contractor must provide within five (5) business days of the date on which the Contractor receives the enrollment report from the Department, the ability to verify enrollment by telephone or by another timely mechanism.

12. Choice of Health Professional

The Contractor must have written policies and procedures for assigning each of its enrollees to a PCP. (See 12.a of this section.) Any changes or modifications to these policies and procedures must be submitted by the Contractor to the Department at least thirty (30) calendar days prior to implementation and must be approved by the Department. These policies and procedures shall include the features listed below:

a. Providers Qualifying as PCPs

The following types of specialty providers may perform as PCPs:

i. Pediatricians;

ii. Family and General Practitioners;

iii. Internists;

iv. Obstetrician/Gynecologists;

v. Specialists who perform primary care functions, e.g., surgeons, clinics, including but not limited to Federally Qualified Health Centers, Rural Health Clinics, Health Departments, and other similar community clinics; or

vi. Other providers approved by the Department.

b. Specialists as PCPs

Enrollees with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. The Contractor shall make a good faith effort to ensure that children for whom the PCP is a specialist receives EPSDT services, including immunizations and dental services. The Contractor shall have in place procedures for ensuring access to needed services for these enrollees or shall grant these PCP requests, as is reasonably feasible and in accordance with Contractor's credentialing policies and procedures.

c. Enrollee Choice of PCP

The Contractor shall offer each enrollee covered under this Contract the opportunity to choose a PCP affiliated with the Contractor to the extent that open panel slots are available.

d. Default Assignment of PCP

If the enrollee does not request an available PCP prior to the twenty-fifth (25^{th}) day of the month prior to the enrollment effective date, then the Contractor may assign the new enrollee to a PCP within its network, taking into consideration such known factors as current provider relationships (as indicated on the enrollment broker's Health Status Survey Questionnaire), language needs (to the extent they are known), age and sex, enrollment of family members (e.g., siblings), and area of residence. The Contractor then must notify the enrollee in writing, on or before the first effective date of enrollment with the Contractor, of his or her PCP's name, location, and office telephone number.

e. Timing of PCP Assignment

The enrollee must have an assigned PCP from the date of enrollment with the plan.

f. Change of PCP

The Contractor must allow enrollees to select or be assigned to a new PCP when requested by the enrollee, when the Contractor has terminated a PCP, or when a PCP change is ordered as a part of the resolution to a formal grievance proceeding. When an enrollee changes his or her PCP, the Contractor must make the enrollee's medical records or copies thereof available to the new PCP within ten (10) business days from receipt of request.

13. Delay of Enrollment Due To Hospitalization

Enrollees who are inpatients in hospitals, other than those listed in subsection D.2.a. of this Contract, at the scheduled time of enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date are restricted from enrollment with the MCO until the first day of the month following discharge, as set forth in 12 VAC 30-120-370 B. This does not pertain to newborns who are enrolled as described in Article II.D.2.

An enrollee who is discharged from one hospital and admitted to another hospital within twenty-four (24) hours (facility to facility transfers) for continued treatment of the same diagnosis shall not be considered discharged under this section.

14. Enrollee Rights

In accordance with 42 CFR § 438.100, the Contractor shall have written policies and procedures regarding enrollee rights and shall ensure compliance of its staff and affiliated providers with any applicable Federal and State laws that pertain to enrollee rights. Policies and procedures shall include compliance with: Title VI of the Civil Rights Act of 1964 as implemented at 45 CFR Part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR Part 91; the Rehabilitation Act of 1973; and Titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality. At a minimum such enrollee rights include the right to:

a. Receive information in accordance with 42 CFR § 438.10 as described in Article II.D.15-18 of this contract.

b. Be treated with respect and with due consideration for his or her dignity and privacy.

c. Receive information on available treatment options and alternatives presented in a manner appropriate to the enrollee's condition and ability to understand.

d. Participate in decisions regarding his or her health care, including the right to refuse treatment.

e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

f. Request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CFR §§ 164.524 and 164.526.

g. Free exercise of rights and the exercise of those rights does not adversely affect the way the Contractor and its providers treat the enrollee.

h. Be furnished health care services in accordance with 42 CFR §§ 438.206 through 438.210 as described in Article II of this Contract.

15. Enrollee Information Packet

The Contractor shall provide each enrollee, prior to the first day of the month in which their enrollment starts, an information packet indicating the enrollee's first effective date of enrollment. (Reference Article III. for time frames related to enrollment report information exchange.) The Contractor shall utilize at least first class or priority mail delivery services as the medium for providing the member identification cards. The Department must receive a copy of this packet on an annual basis for review. At a minimum, the enrollee information packet shall include:

a. An introduction letter

b. A Medallion II identification card that includes the Medicaid ID number and the enrollee's co-payment responsibility.

c. A description of the service area and Provider Directory listing names, locations, telephone numbers, and non-English languages spoken by contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. This includes at a minimum information on primary care physicians, specialists, and hospitals. Additionally, this directory must identify any restrictions that could impact the enrollee's freedom of choice among network providers. [42 CFR 438.10.f.6]

d. Evidence of Coverage

e. An Enrollee Handbook.

If an individual is re-enrolled within 60 days of disenrollment, the Contractor is only required to send the recipient a new identification card. However, the

complete Enrollee Information Packet must be supplied upon request by the recipient.

16. Evidence of Coverage

After obtaining preliminary approval from the Bureau of Insurance, the Contractor shall submit a copy of the Evidence of Coverage to the Department for approval thirty (30) calendar days prior to distribution. The Department will respond within thirty (30) calendar days of the date of the Department's receipt of the request. The Contractor shall deliver an Evidence of Coverage to all enrollees in compliance with § 38.2-4306 of the Code of Virginia, as amended.

The Contractor must update the Evidence of Coverage annually, addressing changes in policies through submission of a cover letter explicitly identifying sections that have changed. Such changes must be approved by the Department prior to dissemination to enrollees and shall be submitted to the Department at least thirty (30) calendar days prior to planned use. The Department will respond to changes to the Evidence of Coverage within thirty (30) calendar days of the date of the Department's receipt of the request. If the Department has not responded to the Contractor within thirty (30) days from receipt of the Evidence of Coverage, the Contractor may proceed with its printing schedule. Any changes to content subsequent to printing shall be corrected through an addendum or subsequent printing mutually agreed upon between the Contractor and the Department.

The Evidence of Coverage can be combined with the Enrollee Handbook (see D.18). If combined, the combined document must include all requirements set forth in this contract for the Evidence of Coverage and the Enrollee Handbook. The Contractor's Evidence of Coverage shall reflect a copy of the enrollee rights (reference Attachment XX of this Contract) as provided at open enrollment.

17. Enrollee Handbook

The Enrollee Handbook must be provided to each enrollee (and potential enrollee if requested) after the Contractor receives notice of the enrollee's enrollment and prior to the first day of the month in which their enrollment starts. Once a year the Department will notify managed care enrollees of their right to request and obtain this information from the Contractor. The Handbook must include at a minimum the following information:

a. Table of Contents

b. Enrollee Eligibility

i. Effective date and term of coverage.

ii. Terms and conditions under which coverage may be terminated.

c. Choosing or Changing an MCO

i. Procedures to be followed if the enrollee wishes to change MCOs.

d. Choosing or Changing a PCP

i. Information about choosing and changing PCPs and a description of the role of Primary Care Providers.

e. Making Appointments and Accessing Care

i. Appointment-making procedures and appointment access standards.

ii. A description of how to access all services including specialty care and authorization requirements.

iii. The role of the PCP and the Contractor in directing care.

f. Enrollee Services

i. A description of all available Medallion II covered services, as outlined in Article II.G. of this contract, including preventive services, and an explanation of any service limitations, referral and prior authorization requirements. The description shall include the procedures for obtaining benefits, including family planning services, from out-of-network providers.

ii. A description of the enhanced services that the Contractor offers.

iii. Instructions on how to contact Member or Customer Services of the Contractor and a description of the functions of Member or Customer Services.

iv. Notification that each enrollee is entitled to a copy of his or her medical records and instructions on how to request those records from the Contractor.

v. Instructions on how to utilize the after-hours Medical Advice and Customer Services Departments of the Contractor.

vi. A description of the Contractor's confidentiality policies.

vii. Advice on how enrolled individuals may acquire services that are covered under Medicaid/FAMIS Plus but not under the Medallion II contract. The Department shall provide a list of these services and how they may be accessed.

g. Emergency Care

i. The telephone number to be used by enrollees for assistance in obtaining emergency care.

ii. The definition of an emergency using the "prudent layperson" standard, a description of what to do in an emergency, instructions for obtaining advice on getting care in an emergency, and the fact that prior authorization is not required for emergency services. Enrollees are to be instructed to use the emergency medical services available or to activate emergency services by dialing 911.

iii. A description of how to obtain emergency transportation and other medically necessary transportation.

iv. How to appropriately use emergency services and facilities

v. Information indicating that emergency services are available out-of-network without any financial penalty to the enrollee.

vi. Definition of and information regarding coverage of post-stabilization services in accordance with 42 CFR § 422.113(c) as described in Article II.G.7 of this contract.

vii. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under this contract.

h. Enrollee Identification Cards

i. A description of the information printed on the identification card, including the Medicaid ID number.

ii. A description of when and how to use the identification card.

i. Enrollee Responsibilities

i. A description of procedures to follow if:

(a). The enrollee's family size changes;

(b). The enrollee's address changes;

(c). The enrollee moves out of the Contractor's service area, (where the enrollee must notify the DSS office regarding change of address and must notify the Contractor for assistance to receive care outside of the Contractor's service area until the member is disenrolled);

(d). He or she obtains or has health coverage under another policy or there are changes to that coverage.

ii. Actions the enrollee can make towards improving his or her own health, enrollee responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the Contractor.

iii. Information about advance directives such as living wills or durable power of attorney.

iv. Notification of any pharmacy co-payment the enrollee will be required to pay. Additionally, notification that there are no cost sharing responsibilities for Medicaid/FAMIS Plus covered services other than for pharmacy services.

j. MCO Responsibilities

i. Notification to the enrollee that if he or she has another health insurance policy to notify their local Department of Social Services caseworker. Additionally, inform the enrollee that the MCO will coordinate the payment of claims between the two insurance plans.

k. Grievances and Appeals [42 CFR §438.10(f)]

i. A description of the grievance and appeals procedures including, but not limited to, the issues that may be resolved through the grievance or appeals processes; the fact that enrollees have the right to appeal directly to the Department for a State fair hearing and providing the Department's address for the appeals; the process for

obtaining necessary forms; and procedures and applicable timeframes to register a grievance or appeal with the Contractor or the Department as described in Article II.S. of this Contract.

ii. The availability of assistance in the filing process.

iii. The toll-free numbers that the enrollee can use to file a grievance or an appeal by telephone.

iv. A description of the continuation of benefits process as required by 42 CFR 438.420 and information describing how the enrollee may request continuation of benefits, as well as information on how the enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.

v. The telephone numbers to register complaints regarding providers (Health Professionals, 1-800-533-1560) and MCOs (Bureau of Insurance, 1-800-552-7945).

l. Interpretation and Translation Services

i. Information on how to access oral interpretation services, free of charge, for any non-English language spoken. [42CFR438.10(c)(5)(i)]

ii. A multilingual notice that describes translation services that are available and provides instructions explaining how enrollees can access those translation services. [42CFR438.10(c)(5)(i)]

As the size of the Contractor's non-English speaking enrollee population attains the threshold specified in Section F below for translation of the enrollee handbook into a language other than English, the Contractor shall be responsible for such translation as required by Article II. Some of this information may be included as inserts in or addenda to the Evidence of Coverage. As the enrollee handbook is translated into other languages, the Contractor shall provide a language appropriate copy to all such non-English speaking enrollees.

iii. Information on how to access the handbook in an alternative format for special needs individuals including, for example, individual's with visual impairments. [42CFR438.10(d)(2)]

m. Program or Site Changes

i. When there are program or service site changes, the Contractor shall ensure that affected enrollees are notified of any changes at least fourteen (14) calendar days prior to their implementation.

n. Additional Information that is available upon request, including the following:

i. Information on the structure and operation of the Contractor.

ii. Physician incentive plans as set forth in 42 CFR 438.6(h).

E. ENROLLEE IDENTIFICATION CARD

1. Enrollment Verification

The Department, or its duly authorized representative, shall provide the Contractor on a monthly basis a listing of all Medallion II enrollees who have selected or been assigned automatically to the Contractor's plan. The listing, or "enrollment report," shall be provided to the Contractor sufficiently in advance of the enrollee's enrollment effective date to permit the Contractor to fulfill its identification card issuance and PCP notification responsibilities, described elsewhere in this Contract. Should the enrollment report be delayed in its delivery to the Contractor, the applicable timeframes for identification card issuance and PCP notification shall be extended by one (1) business day for each day the enrollment report is delayed. The Department and the Contractor shall reconcile each enrollment report as expeditiously as is feasible.

2. Enrollee Identification Card

The Contractor shall provide each enrollee an identification card that is recognizable and acceptable to the Contractor's network providers. The Contractor's identification card must also serve as sufficient evidence of coverage for non-participating providers. The Contractor's identification card will include, at a minimum, the name of the enrollee, the Medicaid/FAMIS Plus identification number, enrollee co-payment responsibility (as applicable), the name and address of the Contractor, the name of the enrollee's primary care provider, a telephone number to be used to access after-hours non-emergency care, instructions on what to do in an emergency, and a Contractor identification number, if applicable. The Contractor must submit and receive approval of the identification card from the Bureau of Insurance and the Department prior to production of the cards.

The Contractor shall provide each enrollee, prior to the first day of the month in which their enrollment starts, an identification card. The Contractor must be prepared to accept the enrollment report on or after the twentieth (20th) day of each month. The Contractor must mail all enrollee identification cards, utilizing at least first class or priority mail delivery services, in envelopes marked with the phrase "Return Services Requested."

The Contractor shall provide the Department on a monthly basis the date and the number of identification cards mailed to new members enrolled each month and the number of identification cards that were re-issued during the prior month. Additionally, the Contractor shall submit a monthly report of returned I.D. cards. The report must identify all returned cards, with the enrollee's Medicaid/FAMIS Plus identification number, incorrect address, and correct address, if available.

F. COMMUNICATION STANDARDS

The Contractor shall participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.

The Contractor shall ensure that documents for its membership, such as the enrollee handbook, are comprehensive yet written to comply with readability requirements. For the purposes of this Contract, no program information document shall be used unless it achieves a Flesch total readability score of forty (40) or better (at or below a 12^{th} grade educational level). The document must set forth the Flesch score and certify compliance with this standard. (These requirements shall not apply to language that is mandated by Federal or State laws, regulations or agencies.) Additionally, the Contractor shall ensure that written membership material is available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited. [42CFR438.10(d)(1)(ii)]

The Contractor must make available enrollee handbooks in languages other than English when five percent (5%) of the Contractor's enrolled population is non-English speaking and speak a common language. The populations will be assessed by Medallion II regions and will only affect handbooks distributed in the affected region.

The Contractor must institute a mechanism for all enrollees who do not speak English to communicate effectively with their PCPs and with Contractor staff and subcontractors.

Oral interpretation services must be available to ensure effective communication regarding treatment, medical history, or health education. [42CFR438.10(c)(4)] Trained professionals shall be used when needed where technical, medical, or treatment information is to be discussed with the enrollee, a family enrollee or a friend. If five hundred (500) or more of its enrollees are non-English speaking and speak a common language, the Contractor must include, if feasible, in its network at least two (2) medically trained professionals who speak that language. In addition, the Contractor must provide TTY/TDD services for the hearing impaired.

All enrollment, disenrollment and educational documents and materials made available to Medallion II enrollees by the Contractor must be submitted to the Department for its review annually, unless specified elsewhere in this contract.

G. PROVISION OF CONTRACT SERVICES

Throughout the term of this Contract, the Contractor shall promptly provide, arrange, purchase or otherwise make available all services required under this Contract to all of its Medallion II enrollees. (A chart summarizing Medallion II covered services, Medallion II carved-out services, Medicaid/FAMIS Plus covered services, and Medicaid/FAMIS Plus non-covered services is provided in Attachment II to this Contract.)

1. Medallion II Covered Services

The Contractor shall provide, arrange for, purchase or otherwise make available the full scope of Medallion II services, with the exception of the carved-out services defined in Article II and other exceptions noted in this Article to which persons are entitled under the State Plan for Medical Assistance (State Plan), as amended, and as further defined by written Department policies (including, but not limited to, agreements, statements, provider manuals, Medicaid memorandums, instructions, or memoranda of understanding) and all applicable State and Federal regulations, guidelines, transmittals, and procedures. Brief descriptions of Medallion II covered services are provided in this Article.

In no case shall the Contractor establish more restrictive benefit limits for medically necessary services than those established by Medicaid as defined in the State Plan and other documents identified above. The Contractor shall manage service utilization through utilization review, prior authorization, and case management, but not through the establishment of benefit limits for medically necessary services that are more restrictive than those established by Medicaid. In accordance with 42 CFR §438.210, the Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.

Coverage decisions that depend upon prior authorization and/or concurrent review to determine medical necessity must be rendered in accordance with the requirements described in Article II. Section L. of this Contract.

The Contractor shall assume responsibility for all covered medical conditions of each enrollee as of the effective date of coverage under the Contract, regardless of the date on which the condition arose. The Contractor shall cover all pre-existing conditions. This responsibility for all covered medical conditions shall not apply in the case of persons temporarily excluded from enrollment due to hospitalization.

2. Abortions

Under the terms of this contract, the Contractor shall not cover services for abortion, as detailed in Attachment II of "Covered Services." All requests for abortions shall be forwarded to the Department for review to ensure compliance with Federal Medicaid rules. The Department will be responsible for payment of these services under the fee-for-service program.

3. Clinic Services

The Contractor shall cover clinic services which are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided to outpatients and are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients, as set forth in 12 VAC 30-50-180. With the exception of nurse-midwife services, clinic services are furnished under the direction of a physician or a dentist. Renal dialysis clinic visits are also covered.

4. Colorectal Cancer Screening

The Contractor shall cover colorectal cancer screening in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.

5. Court-Ordered Services

The Contractor shall be liable for covering all Medallion II-covered, court-ordered services, with the exception of those which the Contractor has determined are not medically necessary, in accordance with the terms set forth in this Contract. In the absence of an agreement otherwise, out-of-network payments will be made in accordance with the Medicaid fee schedule.

6. Dental Services

The Contractor shall cover dental services for individuals under twenty-one (21) years of age in fulfillment of EPSDT treatment requirements, as set forth in 12 VAC 30-50-190 and 12 VAC 30-50-130. These services are defined as routine diagnostic, preventive, or restorative procedures necessary for oral health provided by or under the direct supervision of a dentist. Tooth guidance appliances, complete and partial dentures, surgical preparation for prosthetics, single permanent crowns, and bridges must also be covered but can be subject to prior authorization. The Contractor is not required to cover routine bases under restorations.

The Contractor shall cover full-banded orthodontics and related services for its enrollees under age twenty-one (21) if the required Salzman Index score is met. The Contractor shall reimburse providers for orthodontics according to the Medicaid payment schedule. Reimbursements for approved services are to be paid on a quarterly basis. Forty percent (40%) of the total bill is to be reimbursed in the first quarter and twenty percent (20%) for each subsequent three-month period until full reimbursement is made. The date of the banding starts the first quarter for reimbursement. Post treatment stabilization retainers and follow-up visits are included in the reimbursement for orthodontic services.

The Contractor shall cover limited oral surgery for all enrollees, as set forth in 12 VAC 30-50-190.

7. Emergency Services

The Contractor shall cover emergency and post stabilization services rendered by qualified participating or non-participating providers after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

i. Placing the client's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;

ii. Serious impairment to bodily functions; or,

iii. Serious dysfunction of any bodily organ or part.

In accordance with 42 C.F.R. § 434.30, the Contractor shall ensure that all covered emergency services are available, without requiring prior authorization, twenty-four (24) hours a day and seven (7) days a week through the Contractor's network.

In accordance with 42 CFR §438.114, the Contractor may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Additionally the Contractor shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider or the Contractor of the enrollee's screening and treatment within ten (10) calendar days of presentation for emergency services. Title 42 CFR §438.114 further requires that an enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

The Contractor may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical

condition under the "prudent layperson" standard, as defined herein, was in fact non-emergency in nature.

In accordance with Section 1867 of the Social Security Act, hospitals that offer emergency services are required to perform a medical screening examination on all people who come to the hospital seeking emergency care, regardless of their insurance status or other personal characteristics. If an emergency medical condition is found to exist, the hospital must provide whatever treatment is necessary to stabilize that condition. A hospital may not transfer a patient in unstabilized emergency condition to another facility unless the medical benefits of the transfer outweigh the risks, and the transfer conforms to all applicable requirements. When emergency services are provided to an enrollee of the Contractor, the organization's liability for payment is determined as follows:

a. **Presence of a Clinical Emergency** - If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, the Contractor must pay for both the services involved in the screening examination and the services required to stabilize the patient.

b. **Post Stabilization Care** - The Contractor shall pay for all emergency services which are medically necessary until the clinical emergency is stabilized and until the patient can be safely discharged or transferred. This shall include payment for post stabilization care; or services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized. Coverage shall include treatment that may be necessary to assure, within reasonable medical probability, that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the patient or transfer of the patient to another facility.

If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the Contractor. The Contractor may establish arrangements with hospitals whereby the Contractor may send one of its own physicians with appropriate ER privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the patient.

Coverage and payment for post stabilization care services must be in accordance with provisions set forth in 42 CFR § 422.113(c), as described below.

1. Coverage - The Contractor shall cover post-stabilization care services that are:

   i. Pre-approved by a plan provider or the MCO;
   ii. Not pre-approved by a plan provider or the MCO, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MCO for pre-approval of further post-stabilization care services;
   iii. Not pre-approved by a plan provider or the MCO, but administered to maintain, improve, or resolve the enrollee's stabilized condition if:
      a. The MCO does not respond to a request for pre- approval within 1 hour;
      b. The MCO cannot be contacted; or
      c. The MCO and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a plan physician, and the treating physician may continue with care of the patient until a plan physician is reached or until one of the criteria listed in number 2 below is met.

2. Payment - In accordance with 42 CFR §438.113 (c)(3), the Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when:

   i. A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
   ii. A plan physician assumes responsibility for the enrollee's care through transfer;
   iii. The Contractor and the treating physician reach an agreement concerning the enrollee's care; or,
   iv. The enrollee is discharged.

c. Absence of a Clinical Emergency - If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, the Contractor shall pay for all services involved in the screening examination if the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention

under the "prudent layperson" standard, as defined herein. If an enrollee believes that a claim for emergency services has been inappropriately denied by the Contractor, the enrollee may seek recourse through the MCO or State appeal process.

d. **Referrals** - When an enrollee's primary care physician or other plan representative instructs the enrollee to seek emergency care in-network or out-of-network, the MCO shall be responsible for payment for the medical screening examination and for other medically necessary emergency services, without regard to whether the patient meets the "prudent layperson" standard, as defined herein.

The Contractor shall cover those medical examinations performed in emergency departments for enrolled children as part of a child protective services investigation. In the absence of an agreement otherwise, these services shall be reimbursed at the applicable Virginia Medicaid fee-for-service program rate in effect at the time the service was rendered.

The Contractor may require that continuing care, following the conclusion of an emergency, be obtained from a network provider or another health care provider specified by the Contractor. An emergency shall be deemed to have concluded at such time as the enrollee can, without medically harmful consequences, travel or be transported to an appropriate Contractor facility or to such other facility as the Contractor may designate.

In the absence of an agreement or otherwise, all claims for emergency services shall be reimbursed at the applicable Medicaid fee-for-service program rate in effect at the time the service was rendered. Required payments for emergency services are summarized in the table below and in 12 VAC 30-50-300, 12 VAC 30-50-310, and 12VAC 30-120-395.

Provider	Non-Emergency Condition	Emergency Condition
In-Network	Negotiated rate or, in absence of such, Medicaid triage fee in effect at the time the service was rendered	Negotiated rate or, in absence of such, applicable Medicaid fee-for-service rate in effect at the time the service was rendered
Out-of-Network	Triage fee set at a negotiated rate but not lower than the Medicaid triage fee or, in the absence of such, the Medicaid triage fee in effect at the time the service was rendered	Applicable Medicaid fee-for-service rate in effect at the time the service was rendered

8. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Early and Periodic Screening Diagnosis and Treatment (EPSDT) program is a comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA89) legislation and includes periodic screenings; and vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care services listed in Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid Plan to the rest of the Medicaid population.

a. Screenings

Comprehensive, periodic health assessments, or screenings, from birth through age 20, at intervals as specified in the EPSDT medical periodicity schedule established by the Department. The medical screening shall include:

i. A comprehensive health and developmental history, including assessments of both physical and mental health development.

ii. A comprehensive unclothed physical examination, including:

(a) vision and hearing screening;

(b) dental inspection; and

(c) nutritional assessment.

iii. Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practice (ACIP) for pediatric vaccines. Immunizations shall be reviewed at each screening examination, and necessary immunizations should be administered at the time of the examination.

iv. Appropriate laboratory tests: The following recommended sequence of screening laboratory examinations shall be provided by the Contractor; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary.

(a) hemoglobin/hematocrit

(b) urinalysis

(c) tuberculin test (for high-risk groups)

(d) blood lead testing including capillary specimen (fingerstick) in accordance with EPSDT periodicity schedules and guidelines using blood level determinations as part of scheduled periodic health screenings appropriate to age and risk and in accordance with the EPSDT schedule. A blood lead test result equal to or greater that 10 ug/dL obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample.

All testing shall be done through a blood lead level determination. Results of lead testing, both positive and negative results, shall be reported to The Virginia Department of Health, Office of Epidemiology.

v. Health education/anticipatory guidance.

vi. Referral for further diagnosis and treatment or follow-up of all correctable abnormalities uncovered or suspected.

vii. EPSDT screening services shall reflect the age of the child and shall be provided periodically according to the following schedule:

a) neonatal exam
b) under 6 weeks
c) 2 months
d) 4 months
e) 6 months
f) 9 months
g) 12 months
h) 15 months
i) 18 months
j) 2 years
k) 3 years
l) 4 years
m) 5 years
n) bi-annually from age 6 through 20 years

b. Vision Services

Periodic vision assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum according to the

Department's EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in vision, including eyeglasses. Vision screening in an infant shall mean, at a minimum, eye examination and observation of responses to visual stimuli. In an older child, screening for visual acuity shall be done.

c. Hearing Services

All newborn infants will be given a hearing screening before discharge from the hospital after birth. Those children who did not pass the newborn hearing screening, those who were missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.

Periodic auditory assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum at intervals recommended in the Department's EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in hearing, including hearing aids. Hearing screening shall mean, at a minimum, observation of an infant's response to auditory stimuli. Speech and hearing assessment shall be part of each preventive visit for an older child.

d. Dental Services

Comprehensive preventive, restorative and emergency dental services furnished according to the Department's EPSDT periodicity schedule provided or under the supervision of a licensed dentist. At a minimum, these services shall include relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services. Dental screening in this context shall mean, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection. A referral to a dentist at or after one year of age is recommended. A referral to a dentist shall be mandatory every six months beginning at age three through age 20.

The contractor shall report their dental utilization information annually to the Department.

e. Other

i. Such other medically necessary health care, diagnostic services, treatment, and other measures as needed to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

ii. The Contractor shall inform enrollees about EPSDT services.

iii. EPSDT services shall be subject to all the Contractor's documentation requirements for its network provider services. EPSDT services shall also be subject to the following additional documentation requirements:

a. The medical record shall indicate which age-appropriate screening was provided in accordance with the periodicity schedule and all EPSDT related services whether provided by the PCP or another provider.

b. Documentation of a comprehensive screening shall, at a minimum, contain a description of the components described herein.

iv. The Contractor shall assure that a participating child is periodically screened and treated in conformity with the periodicity schedule. To comply with this requirement, the Contractor shall design and employ policies and methods to assure that children receive rescreening and treatment when due. If the family requests assistance with transportation and scheduling to receive services, the Contractor is to provide this assistance.

v. The Contractor shall incorporate EPSDT requirements in its quality assurance activities.

vi. When a developmental delay has been identified by the provider, the Contractor shall ensure appropriate referrals are made and documented in the patient's records.

9. Early Intervention Services

The Contractor shall cover all medically necessary, Medicaid/FAMIS Plus covered services for children from birth to age three who are determined eligible for Part C services of the Individuals with Disabilities Act by the Department of Mental Health Mental Retardation and Substance Abuse Services or applicable Early Intervention Interagency Council. The Contractor shall cover medically necessary services, including rehabilitative therapies within the amount duration and scope as defined in 12VAC30-130-10 and 12VAC30-50-200. All services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be

reasonable. The Contractor or its designated subcontractor may require prior authorization of services for the purposes of determining medical necessity of therapies and services.

10. Family Planning Services and Supplies

The Contractor shall cover all family planning services which includes services and supplies for individuals of childbearing age which delay or prevent pregnancy, but does not include services to treat infertility or to promote fertility. Medallion II covered services include drugs, supplies, and devices provided under the supervision of a physician, as set forth in 12 VAC 30-50-130 and 42 C.F.R. § 42 C.F.R. § 441.20.

In accordance with 1902 (a)(23)(B) of the Social Security Act and 42 C.F.R. § 431.51(b)(2), as amended, the Contractor may not restrict an enrollee's choice of provider for family planning services or supplies. The Contractor must cover all family planning services and supplies provided by network providers and by out-of-network providers. Code of Virginia § 54.1-2969 (D), as amended, states that minors are deemed adults for the purpose of consenting to medical services required in case of birth control, pregnancy or family planning, except for purposes of sexual sterilization.

The Contractor shall ensure that the consent form of 42 C.F.R. § 441.259 is both obtained and documented prior to the performance of any sterilization under this Contract. Specifically, there must be documentation of the enrollee being informed, the enrollees giving written consent, and the interpreter, if applicable, signing and dating the consent form prior to the procedure being performed. The Contractor shall not perform sterilization for an enrollee under age twenty-one (21). The Contractor shall comply with the requirements set forth in 42 C.F.R. § 441, Subpart F, as amended, and shall comply with the thirty (30) calendar day waiting period requirement as specified in Code of Virginia, § 54.1-2974.

The Department's Family Planning Program as approved in the 1115 Waiver by the Centers for Medicare and Medicaid Services is not covered under the Medallion II program.

11. General Obstetrical Hospital Services

The Contractor shall cover stays in general acute care hospitals as set forth in 12 VAC 30-50-100. The length of stay for vaginal and cesarean births shall be consistent with 12 VAC 30-50-100 including provisions for early discharge and home visits as set forth in 12 VAC 30-50-220.

12. High-Risk Prenatal and Infant Services Program

a. The Contractor shall provide or arrange for services for pregnant women and children up to age 2 which are comparable to the

services described in 12 VAC 30-50-410, 12 VAC 30-50-280 and 12 VAC 30-50-290. These services shall address the following major goals:

i. To reduce infant mortality and morbidity.

ii. To ensure provision of comprehensive services to pregnant women, postpartum women, infants and toddlers up to age two (2).

iii. To assist pregnant and postpartum women and caretakers of infants in meeting other priority needs that affect their well-being and that of their families. These needs may include non-medical needs and non-covered services.

b. The Contractor shall submit a plan annually to DMAS which fully describes the services for high risk pregnant women and infants they will provide, how these services are intended to meet the above described program goals, and how they will measure and monitor program health care outcomes. The Contractor will report on the outcomes of measurements and outcomes annually. Program services shall include, at a minimum, the following:

i. Case management services for high-risk pregnant women and children that include coordination of services for maternal and child health to minimize fragmentation of care, reduce barriers, and link clients with appropriate services to ensure comprehensive, continuous health care. These coordination services will include:

(a) Assessment to determine clients' needs which includes psychosocial, nutrition, and medical factors.

(b) Service planning to develop individualized descriptions of what services and resources are needed to meet the service needs of the client and how to access those resources.

(c) Coordination and referrals that will assist the client in arranging for appropriate services and ensure continuity of care.

(d) The Contractor shall develop and offer expanded prenatal care services for all pregnant women comparable to those described in 12 VAC 30-50-510 and 12 VAC 30-50-290. They shall provide a comprehensive prenatal care service package which

may include services such as patient education, homemaker services, nutritional assessment and counseling, and provision of blood glucose meters when medically necessary.

c. The Contractor shall report summary and detailed information as reflected in Attachment XV – High Risk Maternity and Infant Program Report to the Department on a quarterly basis.

13. Home Health Services

The Contractor shall cover home health services, including nursing services and home health aide services, as set forth in 12 VAC 30-50-160. The Contractor is not required to cover the following home health services, except if ordered by a physician as a result of an EPSDT screen or high-risk pregnancy screen: medical social services, services that would not be paid for by Medicaid/FAMIS Plus if provided to an inpatient of a hospital, community food service delivery arrangements, domestic or housekeeping services which are unrelated to patient care, custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care services, and services related to cosmetic surgery.

Visits by a licensed nurse and home health aide services shall be covered as medically necessary. Rehabilitation services (physical therapy, occupational therapy, and speech-language therapy) shall also be covered under the enrollee's home health benefit, in accordance with the guidelines cited in subsection 23 of Article II.G.

14. Inpatient Hospital Services

The Contractor shall cover inpatient hospital stays in general acute care and rehabilitation hospitals for all enrollees. The Contractor's pre-authorization process for inpatient hospital services must be congruent with guidelines detailed in Article II.L. of this Contract.

15. Inpatient Rehabilitation Hospitals

The Contractor shall cover inpatient rehabilitation services in facilities certified as rehabilitation hospitals and rehabilitation hospitals which have been certified by the Department of Health to meet the requirements to be excluded from the Medicare Prospective Payment System, as set forth in 12 VAC 30-50-200 and 12 VAC 30-50-225.

16. Laboratory and X-Ray Services

The Contractor shall cover all laboratory and x-ray services ordered, prescribed and directed or performed within the scope of the license of a practitioner of the

healing arts, as set forth in 12 VAC 30-50-120. All laboratory testing sites providing services under this Contract must have Clinical Laboratory Improvement Amendments (CLIA) certification and either a clinical laboratory license, a certification of waiver, or a certificate of registration and an identification number. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of the waiver. Laboratories with certificates of registration may perform the full range of services for which they are certified.

17. Medical Supplies and Equipment

All medically necessary medical supplies and equipment shall be covered as set forth in 12 VAC 30-50-160. For a complete listing of Medicaid covered medical supplies and equipment refer to the Durable Medical Equipment (DME) and Supplies Appendix B of the Medicaid DME Provider Manual, as amended.

Coverage of enteral nutrition (EN) and total parenteral nutrition (TPN) which do not include a legend drug is only required when the nutritional supplement is the sole-source form of nutrition (except for enrollees under age twenty-one (21), where the supplement must be the primary source of nutrition), is administered orally or through nasogastric or gastrotomy tube, and is necessary to treat a medical condition. Sole source means that the enrollee is unable to handle (swallow or absorb) any other form of oral nutrition. Primary source means that the nutritional supplements are medically indicated for the treatment of the enrollee's condition. Coverage of enteral nutrition and total parenteral nutrition shall not include the provision of routine infant formula.

18. Nurse-Midwife Services

The Contractor shall cover the services of nurse-midwives as allowed under licensure requirements and Federal law, as set forth in 12 VAC 30-50-260.

19. Nursing Homes

The Contractor is not required to cover nursing facility care. However, the Contractor shall make a good faith effort to refer all members in need of nursing facility care to be prescreened prior to admission. This screening must be done regardless of the recipient's anticipated length of stay in the nursing facility setting.

Once a recipient is screened, authorized, and enters a nursing facility, the nursing facility submits a Patient Intensity Rating Survey (PIRS) form to DMAS (First Health). This information is used to enroll the recipient into the DMAS MMIS system. Once a nursing facility admission is entered into the MMIS system, any open managed care enrollment is closed on the day prior to the nursing facility admission date. The Contractor must cover all medically necessary services until the recipient is disenrolled from the MCO.

20. Organ Transplants

The Contractor shall cover organ transplantation services for kidneys and corneas for all eligible individuals, regardless of age as set forth in 12 VAC 30-50-540 and 12 VAC 30-50-550. The Contractor shall cover services for bone marrow transplants and high-dose chemotherapy for adult (age twenty-one (21) or over) enrollees diagnosed with breast cancer, leukemia, lymphoma and myeloma, as set forth in 12 VAC 30-50-570. The Contractor shall cover liver, heart, and any other medically necessary transplant procedures for enrollees up to age twenty-one (21), as set forth in 12 VAC 30-50-580 and 12 VAC 30-50-560. The Contractor shall cover liver, heart and lung transplantation procedures for individuals over the age of 21 years when medically necessary, as set forth in 12 VAC 30-50-560. Coverage of liver transplants (for adults and children) includes coverage for partial or whole, and orthotopic or heterotopic liver transplantation, from cadaver or living donor, within the amount duration and scope, (and for individuals meeting the criteria) as outlined in 12 VAC 30-50-560, and 12 VAC 30-10-280.

The Contractor must use Department prior authorization criteria or other medically sound, scientifically based criteria in accordance with national standards in making medical necessity determinations for all transplantations. Medical necessity criteria used by the Contractor shall be treated by the Department as proprietary information of the Contractor and shall not be subject to disclosure by the Department. The Contractor is not required to cover transplant procedures determined to be experimental or investigational. Required coverage for transplants is summarized in the following table.

Transplant	Under 21 *	Age 21 and Over	Coverage Criteria
Kidney From Cadaver or Living Donor	Yes	Yes	12VAC30-50-540 12VAC30-10-280
Corneas	Yes	Yes	12VAC30-50-550 12VAC30-10-280
Liver From Cadaver or Living Donor	Yes	Yes	12VAC30-50-560 12VAC30-10-280
Heart	Yes	Yes	12VAC30-50-560 12VAC30-10-280
Lung	Yes	Yes	12VAC30-50-560 12VAC30-10-280
Heart & Lung	Yes	No	12VAC30-50-580 12VAC30-10-280
Bone Marrow	Yes	Yes for limited diagnoses, specifically: myeloma, lymphoma, breast cancer or leukemia	12VAC30-50-560 12VAC30-50-570 12VAC30-10-280
Small Bowel	Yes	No	12VAC30-50-580 12VAC30-10-280
Small Bowel with Liver	Yes	No	12VAC30-50-580 12VAC30-10-280

*Any medically necessary transplants that are not experimental or investigational are covered for children under 21 years of age, when preauthorized.

21. Outpatient Hospital Services

The Contractor shall cover outpatient hospital services which are preventive, diagnostic, therapeutic, rehabilitative or palliative in nature that are furnished to outpatients, except in the case of nurse-midwife services that are furnished under the direction of a physician or a dentist, and are furnished by either a rural health center (RHC), a Federally Qualified Health Center (FQHC), or an institution that is licensed or formally approved as a hospital by an officially designated authority for State standard-setting and meets the requirements for participation in Medicare, as set forth in 12 VAC 30-50-110. Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment or non-routine observation for underlying medical complications. These services must be billed as outpatient care and may be provided for up to 23 hours. A patient stay of 24 hours or more shall require inpatient precertification and admission.

22. Outpatient Mental Health Services

The Contractor is responsible for covering outpatient mental health services at least equal in amount, duration, and scope as described in 12VAC30-50-140 and 12VAC30-50-150.

23. Physical Therapy, Occupational Therapy and Speech-Language Pathology and Audiology Services

The Contractor shall cover all physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP), and audiology services at least equal in amount, duration, and scope as described in 12 VAC 30-50-160, 12 VAC 30-50-200, and 12VAC30-130-40. The scope of coverage for Medicaid/FAMIS Plus specifically includes coverage for both acute and non-acute conditions. Medicaid regulations define "acute conditions" as conditions that are expected to be of brief duration (less than 12 months) in which progress toward goals is likely to occur frequently. "Non-acute conditions" are defined as conditions that are of long duration (greater than 12 months) in which progress toward established goals is likely to occur slowly. PT, OT, SLP, and audiology services are covered regardless of where they are provided, with two exceptions. The Contractor shall not be required to cover school health services (see Article I for the definition of school-based services) or services rendered in a nursing facility. However, the MCO shall not deny outpatient therapies based on the fact that the child is of school age or based upon the fact that the child receives therapy while at school.

The Contractor shall also cover all medically necessary, intensive outpatient physical rehabilitation services in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs), as set forth in 12 VAC 30-50-225.

24. Physician Services and Screenings

The Contractor shall cover all symptomatic visits provided by physicians or physician extenders within the scope of their licenses as set forth in 12 VAC 30-50-140. Cosmetic services are not covered unless performed for medically necessary physiological reasons. The Contractor is only required to cover routine physicals when the services are provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. The Contractor is strongly encouraged to cover routine physicals for enrollees not covered through the EPSDT program.

25. Podiatric Services

The Contractor shall cover podiatric services that are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. The Contractor is not required to cover preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; or acupuncture, as set forth in 12 VAC 30-50-150.

26. Prescription Drugs

The Contractor shall be responsible for covering all prescription drugs for its enrollees, as set forth in 12 VAC 30-50-210, and in compliance with § 38.2-4312.1 of the Code of Virginia.

The Contractor shall cover all Medicaid/FAMIS Plus covered prescription drugs prescribed by providers licensed and/or certified as having authority to prescribe the drug. The Contractor is not required to cover Drug Efficacy Study Implementation (DESI) drugs.

The Contractor shall cover therapeutic drugs even when they are prescribed as a result of non-covered services or carved-out services (e.g., narcotic analgesics after cosmetic surgery).

The Contractor may establish a formulary. However, the Contractor shall have in place authorization procedures to allow providers to access drugs outside of this formulary, if medically necessary and if Medicaid would cover them for fee-for-service enrollees. If the Contractor establishes a formulary, the formulary and pre-authorization requirements must be reported and updated annually to the Department. Any updates to the formulary must be sent to the Department prior to their effective date.

The Contractor shall cover atypical antipsychotic medications developed for the treatment of schizophrenia. The Contractor shall ensure appropriate access to the most effective means to treat, except where indicated for the safety of the patient.

The Contractor shall monitor and report atypical utilization to the Department annually, providing the number of requests and denials.

The Contractor shall follow its authorization procedures within its prescribed time frame and promptly notify both the physician and the pharmacy providers of its decision. The Contractor shall respond to the authorization request within 24 hours. The Contractor's response may be a request for additional information from the provider if this is needed to make the decision. If coverage is denied, the Contractor shall inform the enrollee of his or her rights and the procedures for filing an appeal. If the drug is prescribed for an "emergency medical condition," the MCO must pay for at least a 72-hour supply of the drug to allow the MCO time to make a decision.

The Contractor may impose co-payments on prescription drugs, except for family planning or pregnancy related medications and any medications provided to children. Any implementation of co-payments shall be in accordance with 42 CFR 447.50-447.60 and 12 VAC 30-20-150 and 12 VAC 30-20-160 as described in Article II.G.47 of this contract.

27. Prostate Specific Antigen (PSA)

The Contractor shall cover Prostate Specific Antigen (PSA) testing and digital rectal examinations for the purpose of screening for prostate cancer as set forth in 12 VAC 30-50-220.

28. Prosthetic/Orthotic Services

The Contractor shall cover medically necessary prosthetic and orthotic services and devices at least equal in amount duration and scope as described in 12VAC30-50-210 and 12VAC30-60-120. Coverage for prosthetics includes artificial arms, legs and their necessary supportive attachments, internal body parts (implants), breasts, and eye prostheses when eyeballs are missing and regardless of the function of the eye. The Contractor shall cover medically necessary orthotics (i.e., braces, splints, ankle, foot orthoses, etc.) for enrollees under twenty-one (21) years of age. The Contractor shall cover medically necessary prosthetics and orthotics for an enrollee regardless of the enrollee's age when recommended as part of an approved intensive rehabilitation program as described in 12VAC30-60-120.

29. Psychiatric Hospitals

The Contractor shall cover all services rendered in free-standing psychiatric hospitals to enrollees up to twenty-one (21) years of age and enrollees over sixty-four (64) years of age. Inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital shall be covered for all eligible enrollees regardless of the age of the enrollee, as set forth in 12 VAC 30-50-100.

For admission to a free-standing psychiatric hospital, and for psychiatric services resulting from an EPSDT screening, a certification of the need for services as defined at 42 C.F.R. §441.152 by an interdisciplinary team meeting the requirements of 42 C.F.R. §441.153 or §441.156 and the Psychiatric Inpatient Treatment of Minors Act (§16.1-335 et seq. Code of Virginia), must be completed. Prior to the signing of the contract and upon any change in their procedures, the Contractor shall provide documentation to the Department detailing how this requirement will be met.

All inpatient mental health admissions for individuals of any age to general acute care hospitals shall be approved by the Contractor using its own prior authorization criteria, consistent with the guidelines described in Article II.L. of this Contract. All inpatient psychiatric admissions for individuals under twenty-one (21) and over sixty-four (64) years of age to freestanding psychiatric facilities shall also be approved by the Contractor using its own prior authorization criteria.

30. Routine Childhood Immunizations

The Contractor shall ensure that providers render immunizations, in accordance with the EPSDT periodicity schedule specified in the most current Advisory Committee on Immunization Practices (ACIP) Recommendations, concurrently with the conduct of the EPSDT screening and that enrollees are not inappropriately referred to other providers for immunizations. The Contractor shall, as set forth elsewhere in this Contract, work with its network providers to achieve the Federal immunization performance standards.

The Contractor shall report annually to DMAS the percentage of two-year-old enrollees who have received each immunization specified in the most recent ACIP standards.

The Contractor is responsible for educating providers about reimbursement of immunizations, educating enrollees about immunization services, and coordinating information regarding enrollee immunization. The Contractor shall encourage all PCPs who administer childhood immunizations to enroll in the Virginia Vaccines for Children Program, administered by the Virginia Department of Health. The capitation rate paid to the Contractor shall include the fee for the administration of the vaccines.

31. Second Opinions

The Contractor shall provide coverage for a second opinion when requested by the enrollee for the purpose of diagnosing an illness and/or confirming a treatment pattern of care. The Contractor must provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee. The Contractor may require an authorization to receive specialty care for an appropriate provider; however, cannot deny a second opinion request as a non-covered service.

32. Telemedicine Services

The Contractor shall provide coverage for telemedicine services at least to the extent covered by the Department. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. The Department recognizes physicians, nurse practitioners, nurse midwives, clinical nurse specialists-psychiatric, clinical psychologists, clinical social workers, licensed and professional counselors for medical telemedicine services and requires one of these types of providers at the main (hub) and satellite (spoke) sites for a telemedicine service to be reimbursed. Federal and State laws and regulations apply, including laws that prohibit debarred or suspended providers from participating in the Medicaid program. All telemedicine activities shall be compliant with HIPAA requirements.

The following table details the specific services and procedure codes utilized by the Department in relation to coverage for telemedicine.

Telemedicine Services and Procedure Codes

Main (Hub) Site Service Description	CPT Code	Modifier
Consultation	99241-99275	GT
Main (Hub) Site Service Description	**CPT Code**	**Modifier**
Office visits	99201-99215	GT
Individual psychotherapy	90804-90809	GT
Pharmacological management	90862	GT
Colposcopy	57452, 57454, 57460	GT
Obstetric ultrasound	76805, 76810	GT
Echocardiography, fetal	76825	GT
Cardiography interpretation and report only	93010	GT
Echhocardiography	99307, 99308, 99320, 99321, 99325	GT

Distance (Spoke) Site Service Description	HCPCS Code	Modifier
Telehealth originating site facility fee *	Q3014	GT
*If a higher-level service than Q3014 is medically necessary, DMAS requires the provider to use the most appropriate CPT code, as listed above in the "hub site" section.	See the CPT codes listed above.	GT

33. Temporary Detention Order (TDO)

Pursuant to 42 CFR 441.150 and the Code of Virginia, 16.1-335 et seq. and 37.1-67.1 et. seq., the Contractor shall provide, honor and be responsible for all requests for payment of services rendered as a result of a Temporary Detention Order (TDO) for Mental Health Services. The medical necessity of the TDO services is assumed by the Department to be established, and the Contractor may not withhold or limit services specified in a TDO. Services such as an acute

inpatient admission cannot be denied based on a diagnosis while the client is under TDO for Mental Health Services. For a minimum of twenty-four (24) hours with a maximum of 96 hours, a psychiatric evaluation for mental disorder or disease will occur. At the time of the hearing, based on the psychiatric evaluation and treatment while under the TDO for Mental Health Services, a legally appointed judge will make a determination.

When an out-of-network provider provides TDO services, the Contractor shall be responsible for reimbursement of these services. In the absence of an agreement otherwise, all claims for TDO service shall be reimbursed at the applicable Medicaid fee-for-service rate in effect at the time the service was rendered.

If it is determined by the judge, as the result of a hearing, that the client may be transferred without medically harmful consequences, the Contractor may designate an appropriate in-network or out-of-network facility for the provision of care. Utilization review for medical necessity for meeting continued, acute care stay criteria is appropriate after the TDO for Mental Health Services has been concluded.

34. Transportation

The Contractor shall cover emergency transportation as well as non-emergency transportation to ensure that enrollees have necessary access to and from providers of medical services for emergency or non-emergency services. Transportation includes public transportation; taxicab, if one is necessary; ambulance, a wheelchair van; or a Registered Driver, as set forth in 12 VAC 30-50-300 and 12 VAC 30-50-530. The Contractor shall cover air travel for critical needs. The Contractor shall cover transportation to all Medicaid/FAMIS Plus covered services, even if those Medicaid/FAMIS Plus covered services are reimbursed by an out-of-network payor or are carved-out services as defined in this Article. The Contractor shall cover transportation to and from Medicaid/FAMIS Plus covered community mental health and rehabilitation services. The Department allows the Contractor to subcontract for all transportation services.

The Contractor shall assure that provider agreements (through the Contractor or the subcontractor) include the following language:

a. Requirements for Drivers

The Contractor shall assure that all drivers of vehicles transporting recipients meet the following requirements:

i. All drivers shall have a current valid driver's license from the Commonwealth of Virginia.
ii. Drivers shall not have any prior convictions for sexual abuse, barrier crimes, or crimes of violence.

iii. No driver or attendant shall use alcohol, narcotics, illegal drugs or drugs that impair ability to perform while on duty.

iv. All drivers and attendants shall wear or have visible, easily readable proper identification.

B. Requirements for Vehicles

i. All vehicles shall have functioning, clean and accessible seat belts for each passenger seat position. Each vehicle shall utilize child safety seats when transporting children under age five.

ii. All vehicles shall have a functioning speedometer and odometer.

iii. All vehicles shall have the transportation provider's name, vehicle number (if applicable), and the Contractor's phone number prominently displayed within the interior of each vehicle.

iv. Smoking is prohibited in all vehicles while transporting recipients. All vehicles shall post "no smoking" signs in all vehicle interiors, easily visible to the passengers.

v. All vehicles shall be equipped with a first aid kit.

vi. All vehicles must meet State, Federal, local, and manufacturer's safety and mechanical operating and maintenance standards for the vehicles.

vii. Vehicles shall comply with the American's with Disabilities Act (ADA) regulations.

35. Vision Services

The Contractor shall cover vision services which are defined as diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. Routine refractions shall be allowed at least once in twenty-four (24) months. Routine eye examinations, for all enrollees, shall be allowed at least once every two (2) years. The Contractor shall cover eyeglasses and contact lenses prescribed by a physician skilled in diseases of the eye or by an optometrist for enrollees up to age twenty-one (21), as medically necessary and as set forth in 12 VAC 30-50-210.

36. Women's Health Care Services

a. The Contractor shall permit any female enrollee of age thirteen (13) or older direct access, as provided in subsection B of § 38.2-3407.11 of the Code of Virginia, to a participating obstetrician-gynecologist for annual examinations and routine health care services, including pap smears, without prior authorization from the primary care physician. Health care services means the full scope of medically necessary services provided by the obstetrician-

gynecologist in the care of or related to the female reproductive system in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists.

b. The Contractor shall cover mammograms for female enrollees age thirty-five (35) and over, consistent with the guidelines published by the American Cancer Society, as set forth in 12 VAC 30-50-220.

c. The Contractor shall cover breast prostheses following medically necessary removal of a breast for any medical reason as set forth in 12 VAC 30-50-210.

d. The Contractor shall provide coverage for at least a 48-hour hospital stay following a radical or modified radical mastectomy and not less than 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer. Notwithstanding these requirements, the attending physician and the patient can determine that a shorter stay in the hospital is appropriate in accordance with Chapter 709 of 1998 Virginia Acts of Assembly, § 32.1-325 (A) of the Code of Virginia.

e. The Contractor shall cover resconstructive breast surgery in accordance with 12 VAC 30-50-140.

f. The Contractor shall cover services to pregnant women, including:

i. Pregnancy-related and postpartum services for sixty (60) calendar days after the pregnancy ends, as set forth in 12 VAC 30-50-290;

ii. Services to treat any other medical condition that may complicate pregnancy, as set forth in 12 VAC 30-50-290;

iii. Prenatal services, including patient education, nutritional assessment, counseling and homemaker services, as set forth in 12 VAC 30-50-510 and 12 VAC 30-50-290;

iv. Case management services for high-risk pregnant women and infants up to age two (2), as set forth in 12 VAC 30-50-410 and 12 VAC 30-50-280. Case management services for neonatal intensive care.

g. In cases in which the newborn and mother or the newborn alone are discharged earlier than forty-eight (48) hours after the day of

delivery, the Contractor shall cover at least one (1) early discharge follow-up visit as indicated by the most recent "Guidelines for Perinatal Care" developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. The early discharge follow-up visit shall be provided to all mothers and newborns or the newborn alone, if the mother has not been discharged, who meet the Department's criteria for early discharge, as set forth in 12 VAC 30-50-220.

h. The early discharge follow-up visit shall be provided within forty-eight (48) hours of discharge and must include, at a minimum, a maternal assessment and a newborn assessment, as set forth in 12 VAC 30-50-220.

i. The Contractor shall not be responsible for covering Medicaid covered residential or day treatment substance abuse treatment services for pregnant women. The Contractor must have in place written policies and procedures related to the coordination of substance abuse treatment services with other providers and a mechanism whereby enrollees seeking or needing these services may obtain from the Contractor the Department's listing of appropriate providers. The Contractor shall submit to the Department annually for review its policies and procedures addressing coordination of substance abuse services for pregnant women.

j. The Contractor shall ensure that, as a routine component of prenatal care, every pregnant enrollee shall be advised of the value of testing for HIV infection as set forth in 12 VAC 30-50-510 and shall request of each such pregnant enrollee consent to testing as set forth in § 54.1-2403.01 of the Code of Virginia. Any pregnant enrollee shall have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal shall be maintained in the enrollee's medical record.

37. Medallion II Carved-Out Services

a. The Contractor is not required to cover Medallion II carved-out services, which are defined through Medicaid memos, Federal and State laws and regulations, and Medicaid manuals.

b. The following services are Medallion II carved-out services:

i. Community rehabilitation mental health services, mental retardation services, and substance abuse treatment services as set forth in 12 VAC 30-50-130 and 12 VAC 30-50-226.

ii. School health services, defined under the DMAS school-based services regulations at 12VAC30-50-229.1. The services are those therapy, skilled nursing, and psychiatric/psychological services as outlined in the Individual Education Plan (IEP) and rendered to children who qualify under the federal Individuals with Disabilities Education Act. School health services are to be rendered by (1) employees of the school divisions or (2) providers that contract with school divisions and billed by the school division. (Reference the Article I. Definitions section for additional details.)

iii. Targeted case management services provided to seriously mentally ill adults and emotionally disturbed children; youth at risk of serious emotional disturbance; individuals with mental retardation; individuals with mental retardation and related conditions participating in home- and community-based care waivers; the elderly; and recipients of Auxiliary Grants as provided in 12 VAC §§ 30-50-420 through –470.

iv. Investigations by local health departments to determine the source of lead contamination in the home as part of the management and treatment of eligible children who have been diagnosed with elevated blood lead levels, as set forth in 12 VAC 30-50-227.

v. Abortions as set forth in 12 VAC 30-50-180 and 42 C.F.R. § 441.203 and § 441.206.

c. Enrollees who receive any of the following services shall meet the criteria for exclusion from the Medallion II Program. Once the Contractor determines that an enrollee is receiving these services and notifies the Department, the Department will begin the process to exclude the enrollee. Until the Department has excluded the enrollee, the Contractor is responsible for covering Medallion II services for that enrollee. However, in no event is the Contractor responsible for provision of the following services, which will be reimbursed by the Department:

i. Services for enrollees with mental retardation and related conditions, including case management, who are participants in the Home and Community Based Services and Family Planning waivers are carved out as set forth in 12 VAC 30-50-450, 12 VAC 30-120-210 through 30-120-259, and 12 VAC 30-135-10 through 12 VAC 30-135-90.

ii. Inpatient mental health services rendered in a State psychiatric hospital, as set forth in 12 VAC 30-50-230 through 12 VAC 30-50-250.

iii. Hospice services defined as those services allowed under the provisions of Medicare law and regulations as they relate to hospice benefits and as specified in 42 C.F.R., Part 418 and as set forth in 12 VAC 30-50-270.

iv. Skilled nursing facility care, as set forth in 12 VAC 30-50-130.

v. Private duty nursing services, as carved out in 12 VAC 30-50-170 when provided through HCBS waivers covered in 12 VAC 30-120-10 through 30-120-259.

vi. Personal care services in an enrollee's home, when provided through HCBS waivers, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse, as set forth in 12 VAC 30-50-300.

vii. Individuals who are enrolled in DMAS authorized Therapeutic Foster Care (TFC) or Residential Treatment Facility (RTF) programs, as authorized by the Department. If upon authorization for TFC case management services, it is determined by WVMI that the client is enrolled in an MCO, WVMI will notify the MCO Unit by facsimile, confirming E-mail, with documentation necessary to identify the recipient and approved admission date. MCO enrollment will end one day before the authorized admission date to the service. The MCO Unit will annually review the prior authorization files to determine discharge from TFC case management services. When upon discharge from TFC case management services, it is determined that the client is eligible to participate in Medallion II, the recipient will be entered into the pre-assignment process for MCO enrollment.

38. Medallion II Contractor Referral Responsibilities

a. In addition to the referral requirements set forth elsewhere in this Contract, the Contractor shall:

i. Establish referral mechanisms to link enrollees with providers and programs not covered through Medallion II or Medicaid/FAMIS Plus;

ii. Maintain a current list of providers, agencies, and programs; and

iii. Provide the list to enrollees who have needs for those programs.

b. Contractor shall advise the enrollees of the availability of services offered by the following programs, if appropriate to address the needs of the enrollee. The Contractor will coordinate with and refer enrollees to the following programs:

(1) IDEA

The Individuals with Disabilities Education Act Early Intervention Services (IDEA-EIS) program (as described in 20 U.S.C. § 1471 and 34 C.F.R. § Part 303.12) is administered by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. Early intervention services include services that are designated to meet the developmental needs of an infant or toddler with a disability in any one or more of the following areas: physical, cognitive, communication, social or emotional, or adaptive development.

The Contractor shall refer enrollees who are potentially eligible for or qualify for Early Intervention Services to local interagency councils. The Contractor shall maintain a listing of local interagency councils and shall make that listing available to all qualified enrollees.

(2) WIC Programs

Section 1902(a)(11)(C) of the Social Security Act, as amended, requires the State Plan to provide for the coordination of Medicaid and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and is administered by the Virginia Department of Health. The Contractor shall provide for the referral of potentially eligible women, infants, and children to the WIC Program and the provision of medical information by providers working within Medallion II managed care plans to the WIC Program.

(3) Head Start

The Head Start program is authorized under the Head Start Act, 42 U.S.C. § 9831 et seq., as amended.

For all referrals that require the sharing of the enrollee's medical information, the Contractor shall ensure that its network providers obtain necessary written and signed informed consent from the enrollee prior to release of the enrollee's medical information. All requests for medical information shall be consistent with the confidentiality requirements of 42 C.F.R. § Part 431.300 Subpart F.

39. Medicaid/FAMIS Plus Non-Covered Services

The Medallion II Contractor is not responsible for covering DMAS non-covered or Home and Community Based or Family Planning waivered services described in 12 VAC 30-50-450, 12 VAC 30-120-210 through 30-120-259, and 12 VAC 30-135-10 through 12 VAC 30-135-90. Medicaid/FAMIS Plus non-covered services are those services not covered by DMAS and, therefore, not included in the covered services as defined in the Virginia State Plan or State regulations, except if ordered as a result of an EPSDT screen or high-risk pregnancy screen. Some, but not all, Medicaid/FAMIS Plus non-covered services are listed below.

a. Services rendered by chiropractors, as set forth in 12 VAC 30-50-150.

b. Services of Christian Science nurses and care as set forth in 12 VAC 30-50-300(B).

c. Any procedure that is experimental or investigational, as defined by the Department, as set forth in 12 VAC 30-50-140.

40. Coverage of Prior Authorized Services

a. The Contractor (the enrollee's current MCO) shall assume responsibility for all managed care contract covered services authorized by either the Department or a previous MCO, which are rendered after the enrollment effective date, in the absence of a written agreement otherwise. For on-going services, such as home health, outpatient mental health, and outpatient rehabilitation therapies, etc., the Contractor (the enrollee's current MCO) shall continue prior authorized services without interruption until the Contractor completes its utilization review process to determine medical necessity of continued services or to transition services to a network provider.

b. The Department shall assume responsibility for all covered services authorized by the enrollee's previous MCO which are rendered after the effective date of disenrollment to the fee-for-service system, if the enrollee otherwise remains eligible for the service(s).

c. If the prior authorized service is an inpatient stay, the financial responsibility shall be allocated between the Contractor and either the Department or the new MCO. In the absence of a written agreement otherwise, the Contractor and the Department or the new MCO shall each pay for the period during which the enrollee is enrolled with the entity. This also applies to newborns hospitalized at the time of enrollment.

d. If services have been pre-authorized using a provider who is out of network, the Contractor may elect to re-authorize (but not deny) those services using an in-network provider.

41. Out-of-Network Services

a. The Contractor shall cover and pay for all authorized care that it has pre-authorized and provided out of its established network. Out-of-network claims must be paid in accordance with the Medicaid fee schedule in place at the time the service was rendered or at another fee negotiated between the Contractor and the provider of services.

b. The Contractor shall cover and pay for emergency and family planning services rendered to an enrollee by a non-participating provider or facility, as set forth elsewhere in this Contract.

c. The Contractor shall cover, pay for, and coordinate care, rendered to enrollees by out-of-network providers when the enrollee is given emergency treatment by such providers outside of the service area, subject to the conditions set forth elsewhere in this Contract.

d. The Contractor shall cover and pay for services furnished in facilities or by practitioners outside the Contractor's network if the needed medical services or necessary supplementary resources are not available in the Contractor's network.

e. To ensure against adverse disenrollment, the MCO must provide coverage out-of-network for any of the following circumstances:

1. When a service or type of provider (including dentists) is not available within the MCO's network or where the MCO cannot provide the needed specialist within the contract distance standard of more than 30 miles in urban areas or more than 60 miles in rural areas.

2. For up to 30 days to transition the client to an in-network provider when a provider that is not part of the MCO's network

has an existing relationship with the beneficiary, is the beneficiary's main source of care, and has not accepted an offer to participate in the MCO's network.

3. When the providers that are available in the MCO's network do not, because of moral or religious objections, furnish the service the client seeks.

4. When DMAS determines that the circumstance warrants out-of-network treatment.

42. Modification in Scope of Covered Services

The Department, at its sole discretion, may reduce, increase, or otherwise modify covered services required by this Contract. If appropriate, the Department shall modify the capitation payment in an amount deemed, in the sole opinion of the Department, to be appropriate. The Department shall notify the Contractor in advance of any modification to the capitation payment. Should the Contractor be unable or unwilling to provide the increased, reduced, or modified covered services at the capitation rate provided by the Department, the Contract may be terminated by the Contractor following the termination procedures specified in Article VII.

43. Enhanced Services

Enhanced services are those services offered by the Contractor to enrollees in excess of Medallion II covered services. Nothing in this Contract shall preclude the Contractor from providing additional health care health improvement services or other services not specified in this Contract as long as these services are available, as needed or desired, to enrollees. No increased reimbursement will be made for additional services provided by the Contractor under this Contract. The Contractor must inform the Department at least thirty (30) calendar days prior to implementing any new enhanced services and prior to implementing revisions to existing enhanced services. The contractor must report annually the enhanced services it offers.

Enhanced services offered by the Contractor are listed in the Department's Managed Care Program comparison charts. Comparison charts are revised once annually. Any changes to enhanced services occurring after the annual comparison chart publication cannot be incorporated until the next annual revision. Revisions to enhanced services should be made only at open enrollment. However, the contractor may revise enhanced services at any date, if the contractor accepts the cost of revising and printing comparison charts.

The Contractor shall not obtain enrollment through the offer of any compensation, reward, or benefit to the enrollee except for additional health-related services

which have been included in the response to the RFP or have since been added by the Contractor and approved by the Department.

Provision of an enhanced service that is a service qualifying an individual for exclusion from Medallion II shall not be the sole basis for exclusion from Medallion II; in order to be excluded from Medallion II, individuals must meet the Department's criteria for receiving that service.

44. State Laws and Regulations Governing the Provision of Medical Services

The MCO shall be required to comply with all State laws and regulations, including, but not limited to: (1) the Code of Virginia Title 38.2, Chapter 43, as amended; (2) Rules Governing Health Maintenance Organizations, Virginia Administrative Code, Title 14, as amended, Chapter 5-210; (3) Virginia Administrative Code, 12 VAC 30-120-370 through 12 VAC 30-120-420; and (4) Code of Virginia, Title 32.1, Chapter 9.

45. Medical Necessity

The Contractor shall cover all medically necessary services, as defined in this contract, and in accordance with 42 C.F.R. § 440.230, State Plan for Medical Assistance (State Plan), as amended and as further defined by written Department policies (including agreements, statements, provider manuals, Medicaid memorandums, instructions, or memoranda of understanding) and all applicable State and Federal regulations, guidelines, transmittals, and procedures. The actual provision of any service is subject to the professional judgment of the Contractor's providers as to the medical necessity of the service, except in situations in which the Contractor must provide services ordered by the Department pursuant to an appeal from the Contractor's grievance process or an appeal directly to the Department by an enrollee or for emergency services as defined in this Contract. Decisions to provide authorized medical services required by this Contract shall be based solely on medical necessity and appropriateness. Disputes between the Contractor and enrollees about medical necessity may be appealed to the Department by the enrollee or the enrollee's representative.

46. Moral or Religious Objections

In accordance with 42 CFR §438.102 the Contractor shall not be required to provide, reimburse for, or provide coverage of a counseling or referral service if the Contractor objects to the service on moral or religious grounds in accordance with all of the following guidelines:

Information Requirements – The Contractor must furnish information about the services it does not cover:

a. To the Department:

i. With the initiation of the Contract and each subsequent renewal.

ii. Upon adoption of such policy in the event that the Contractor adopts the policy during the term of the contract.

b. To potential enrollees, before and during enrollment.

c. To enrollees, within 30 days before the effective date of this policy.

47. Cost Sharing

The Contractor may impose co-payments on pharmacy services, except for family planning or pregnancy related medications and any medications provided to children. Additionally, in accordance with 42 CFR 447.50-447.60, the Contractor shall not impose any cost sharing obligations on enrollees except as set forth in 12 VAC 30-20-150 and 12 VAC 30-20-160. Therefore, if the Contractor chooses to impose pharmacy co-payments, the co-payment structure must be the same as the Department's fee-for-service co-payment structure.

The Contractor shall include a description of any enrollee pharmacy co-payment responsibility in the enrollee handbook, and shall list the applicable co-payment information on the enrollee identification card.

For the purposes of this contract, the Contractor's decision to implement or change benefits must follow the same guidelines as listed in this contract for enhanced benefits.

H. MEMBER SERVICES

1. The Contractor agrees to maintain and staff a toll-free Member or Customer Services function to be operated at least during regular business hours and to be responsible for the following:

a. Explaining the operation of the MCO, including the role of the PCP and what to do in an emergency or urgent medical situation;

b. Assisting enrollees in the selection of a PCP;

c. Assisting enrollees to make appointments and obtain services;

d. Arranging medically necessary transportation for enrollees; and

e. Handling enrollee inquiries and grievances.

2. Specific standards for ensuring acceptable levels of service are as follows:

a. Waiting/Hold Times

The Contractor shall have appropriate equipment and personnel in place to ensure that daily hold time for a member service Helpline inquiry never exceeds three (3) minutes and that ninety percent (90%) of the callers, at a minimum, will reach a human voice or a hold message within twenty (20) seconds.

b. Abandonment Rate

The Contractor's daily telephone abandonment rate for medical helpline access calls shall be less than ten percent (10%) for all incoming calls.

Records of wait times and abandonment rates shall be kept by the Contractor and reported to the Department monthly. At a minimum the report shall identify the total call volume, wait time (in seconds), and the abandonment percentage rate.

I. ENROLLEE EDUCATION PROGRAM

The Contractor must develop, administer, implement, monitor, and evaluate a program to promote health education services for its new and continuing Medallion II enrollees, as indicated below. For the purposes of this Contract, no program information document shall be used unless it achieves a Flesch total readability score of (40) or better. (These requirements shall not apply to language that is mandated by Federal or State laws, regulations or agencies). The Contractor shall maintain a written plan for health education and prevention which is based on the needs of its enrollees. The Contractor shall submit an annual health education and prevention plan to the Department . At a minimum, the education plan shall describe topics to be delivered via printed materials, audiovisual or face-to-face communications and the time frames for distribution. Any changes to the education plan must be approved by the Department prior to implementation.

The Contractor will be responsible for developing and maintaining enrollee education programs designed to provide the enrollee with clear, concise, and accurate information about the Contractor's health plan. Additionally, the Contractor will provide the Department annually with a copy of all member health education materials, including any news letters sent to its members.

J. PROVIDER NETWORK COMPOSITION AND ACCESS TO CARE STANDARDS

In accordance with 42 CFR §438.206, the Contractor shall maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under this Contract. The Contractor shall meet the following network and access standards:

1. Network Provider Composition

a. The Contractor shall be solely responsible for arranging for and administering covered services to enrolled enrollees and must ensure that its delivery system will provide available, accessible and adequate numbers of facilities, locations and personnel for the provision of covered services. In establishing and maintaining the network, the Contractor shall consider all of the following:

i. the anticipated Medicaid/FAMIS Plus enrollment;

ii. the expected utilization of services, taking into consideration the characteristics and health care needs of the anticipated Medicaid/FAMIS Plus population to be served;

iii. the numbers and types (in terms of training and experience, and specialization) of providers required to furnish the contracted services;

iv. the numbers of network providers not accepting new Medicaid/FAMIS Plus patients;

v. the geographic location of providers and enrollees, considering distance, travel time, and the means of transportation ordinarily used by Medicaid/FAMIS Plus enrollees; and

vi. whether the location provides physical access for enrollees with disabilities.

The Contractor shall include in its network or otherwise arrange care by providers specializing in early childhood, youth and geriatric services. The Contractor is encouraged to develop and maintain a list of referral sources which includes community agencies, State agencies, "safety net" providers, teaching institutions and facilities that are needed to assure that the enrollees are able to access and receive the full continuum of

treatment and rehabilitative medical and outpatient mental health services and supports needed.

b. The Contractor shall notify the Department within thirty (30) business days of any changes to a network provider agreement made by the Contractor, a subcontractor, or network provider regarding termination, pending termination, or pending modification in the subcontractor's or network provider's terms and not otherwise addressed in Attachment V, Section C, that could reduce enrollee access to care.

c. Any physician who provides inpatient services to the Contractor's enrollees shall have admitting and treatment privileges in a minimum of one general acute care hospital that is in the Contractor's network and is located within the contract service area.

d. The Contractor shall submit to the Enrollment Broker and the Department a complete provider file. The file shall be in a Department approved electronic format. The provider file shall be submitted thirty (30) days prior to the effective date of the Contract. An updated file with all of the changes to the network will be submitted monthly thereafter to the Enrollment Broker. The Contractor shall submit to the Department a complete provider file quarterly. Attachment III details the required reporting data elements. Additional required elements to be included in this report may be identified by the Department.

2. Provider Enrollment into Medicaid

The Contractor will ensure that as part of its credentialing process all providers, including ancillary providers, (i.e. dental, vision, pharmacy, etc.) apply for enrollment in the Medicaid program

3. Network Provider Licensing and Certification Standards

Each Contractor must have the ability to determine whether physicians and other health care professionals are licensed by the State and have received proper certification or training to perform medical and clinical services contracted for under this Contract. The Contractor's standards for licensure and certification shall be included in its participating provider network agreements with its network providers which must be secured by current subcontracts or employment contracts.

4. Enrollee-to-PCP Ratios

As a means of measuring accessibility, the Contractor must have at least one (1) full-time equivalent (FTE) PCP, regardless of specialty type, for every 1,500 Medicaid/FAMIS Plus enrollees, and there must be one (1) FTE PCP with pediatric training and/or experience for every 2,500 enrollees under the age of eighteen (18). No PCP may be assigned enrollees in excess of these limits, except where mid-level practitioners are used to support the PCP's practice.

Each contract between the Contractor and any of its network providers who are willing to act as a PCP must indicate the number of open panel slots available to the Contractor for enrollees under this Contract.

This standard refers to the total Medallion II enrollees under enrollment by the Contractor as identified in this Contract. If necessary to meet or maintain appointment availability standards set forth in this Contract, the Contractor shall decrease the number of enrollees assigned to a PCP.

When specialists act as PCPs, the duties they perform must be within the scope of their specialist's license.

5. Specialist Services

The Contractor shall maintain in its network and in its referral listing a number of specialists in the following specialties which is adequate to provide covered services to its Medallion II enrollees:

Adolescent Medicine
Allergy/Immunology
Anesthesiology
Cardiology
Child Psychiatry
Colon/Rectal Surgery
Dermatology
Endocrinology
Gastroenterology
General Surgery
Genetics Metabolism
Hematology
Infectious Diseases
Internal Medicine
Neonatal/Perinatal Medicine
Nephrology
Neurological Surgery
Neurology
Oncology
Ophthalmology
Oral Surgery
Orthopedic Surgery
Otolaryngology
Pediatric Physical Medicine and Rehabilitation
Pediatrics
Pediatric Sub specialists
Periodontists
Physical Medicine/Rehabilitation
Plastic Surgery
Pulmonology
Preventive Medicine
Psychiatry
Psychology
Radiology
Rheumatology
Thoracic Surgery
Urology

6. Enrollee-to-Dentist Ratios

The Contractor must have no more than two thousand (2,000) enrollees under the age of 21 years for each dental team in its network. Dental teams are defined to

consist, at a minimum, of a dentist, a dental hygienist, and, optionally, a dental assistant. The Contractor must have written policies and procedures, which are submitted annually, for providing medically necessary in-plan services when ordered by a non-network dentist.

7. Inpatient Hospital Access

The Contractor shall maintain in its network a sufficient number of inpatient hospital facilities which is adequate to provide covered services to its enrollees. The Contractor shall notify the Department within fifteen (15) calendar days of any changes to its contracts with hospitals if those changes impact the scope of covered services, the number of individuals covered and/or the units of service covered.

8. Policy of Nondiscrimination

The Contractor shall ensure that its providers provide contract services to enrollees under this Contract in the same manner as they provide those services to all non-Medicaid enrollees. Additionally, in accordance with 42 CFR §438.206, the Contractor shall ensure that its network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid/FAMIS plus enrollees.

9. Twenty-Four -Hour Coverage

The Contractor shall maintain adequate provider network coverage to serve the entire eligible Medallion II populations in geographically accessible locations within the region twenty-four (24) hours per day, seven (7) days a week.

In accordance with the Code of Virginia § 38.2 - 4312.3, as amended, the Contractor shall maintain after-hours telephone service, staffed by appropriate medical personnel, which includes access to a physician on call, a primary care physician, or a member of a physician group for the purpose of rendering medical advice, determining the need for emergency and other after-hours services, authorizing care, and verifying enrollee enrollment with the Contractor.

10. Travel Time and Distance

a. Travel Time Standard

The Contractor shall ensure that each enrollee shall have a choice of at least two (2) PCPs located within no more than thirty (30) minutes travel time from any enrollee in urban areas unless the Contractor has a Department-approved alternative time standard. Travel time shall be determined based on driving during normal traffic conditions (i.e., not

during commuting hours). The Contractor shall ensure that each enrollee shall have a choice of at least two (2) PCPs located within no more than sixty (60) minutes travel time from any enrollee in rural areas unless the Contractor has a Department-approved alternative time standard. The Contractor shall ensure that obstetrical services are available within no more than forty-five (45) minutes travel time from any pregnant enrollee in rural areas unless the Contractor has a Department approved alternative time standard.

b. Travel Distance Standard

The Contractor shall ensure that each enrollee shall have a choice of at least two (2) PCPs located within no more than a fifteen (15) mile radius in urban areas and thirty (30) miles in rural areas unless the Contractor has a Department-approved alternative distance standard. The Contractor must ensure that an enrollee is not required to travel in excess of thirty (30) miles in an urban area and sixty (60) miles in a rural area to receive services from specialists, hospitals, special hospitals, psychiatric hospitals, diagnostic and therapeutic services, and physicians, dentists, or other necessary providers, unless the enrollee so chooses. An exception to this standard may be granted when the Contractor has established, through utilization data provided to the Department, that a normal pattern for securing health care services within an area falls beyond the prescribed travel distance or the Contractor, and its PCPs are providing a higher skill level or specialty of service that is unavailable within the service area such as treatment of cancer, burns, or cardiac diseases.

11. Appointment Standards

a. The Contractor must arrange to provide care according to each of the following appointment standards:

i. Appointments for emergency services shall be made available immediately upon the enrollee's request.

ii. Appointments for an urgent medical condition shall be made within twenty-four (24) hours of the enrollee's request.

iii. Appointments for routine care shall be made within thirty (30) calendar days of the enrollee's request. This standard does not apply to appointments for routine physical examinations, nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days.

b. For maternity care, the Contractor shall be able to provide initial prenatal care appointments for pregnant enrollees as follows:

i. First trimester - within fourteen (14) calendar days of request

ii. Second trimester - within seven (7) calendar days of request

iii. Third trimester - within three (3) business days of request

c. Appointments shall be scheduled for high-risk pregnancies within three (3) business days of identification of high risk to the Contractor or maternity provider, or immediately if an emergency exists.

12. Emergency Services Coverage

The Contractor shall ensure that all emergency Medallion II covered services are available twenty-four (24) hours a day, seven (7) days a week, either in the Contractor's own facilities or through arrangements with other subcontractors. The Contractor must designate emergency sites that are as conveniently located as possible for after-hours emergency care.

The Contractor shall negotiate provider agreements with emergency care providers to ensure prompt and appropriate payment for emergency services. Such network provider agreements shall provide for the following:

a. The process for determining a true and actual emergency;

b. The requirements and procedures for contacting the Contractor before administering urgent or routine care; and

c. Agreements between the Contractor and the provider regarding indemnification, malpractice, or other legal liabilities, which would apply to the Contractor or the provider in the absence of such an agreement.

13. Medical HelpLine Access Standards

The Contractor must provide a toll-free telephone line twenty-four (24) hours a day, seven (7) days a week, staffed by medical professionals to assist enrollees. Additionally, the Contractor must advise the Department on an annual basis of the process it utilizes to meet this requirement

14. Assurances That Access Standards Are Being Met

The Contractor must establish a system to monitor its provider network to ensure that the access standards set forth in this Contract are met, must monitor regularly to determine compliance, taking corrective action when there is a failure to comply, and must be prepared to demonstrate to the Department that these access standards have been met.

K. PROVIDER RELATIONS

1. Provider Enrollment

a. The Contractor shall provide adequate resources to support a provider relations function that will effectively communicate with existing and potential network providers. The Contractor shall give each network provider explicit instructions about the Contractor's provider enrollment process, including enrollment forms, brochures, enrollment packets, provider manuals, and participating provider agreements. The Contractor shall provide this information to potential network providers upon request. The Contractor's network provider agreement shall comply with the terms set forth in Attachment V.

b. The Contractor shall not require as a condition of participation/ contracting with physicians, dentists, etc. in their Medicaid/FAMIS Plus network to also participate in the Contractor's commercial managed care network. However, with the exception of Dental Providers, this provision would not preclude a Contractor from requiring their commercial network providers to participate in their Medicaid/FAMIS Plus provider network.

2. Anti-discrimination

Pursuant to Section 1932 (b)(7) of the SSA, the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. Additionally, consistent with 42 CFR 438.214(c), provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. [42CFR438.12(a)]

This section shall not be construed to prohibit the Contractor from including providers only to the extent necessary to meet the needs of the organization's enrollees; or from using different reimbursement amounts; or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor. [42CFR438.12(b)]

3. Provider Education

a. The Contractor shall ensure that all providers receive proper education and training regarding the Medallion II managed care program to comply with this Contract and all applicable Federal and State requirements. The Contractor shall offer educational and training programs that cover topics or issues including, but not limited to, the following:

i. All Medallion II covered services, carved-out and enhanced services, policies, procedures, and any modifications to these items;

ii. Medallion II eligibility standards, eligibility verification, and benefits;

iii. The role of the enrollment broker regarding enrollment and disenrollment;

iv. Special needs of enrollees in general that may affect access to and delivery of services, to include, at a minimum, transportation needs;

v. The rights and responsibilities of the enrollees;

vi. Grievance and appeals procedures;

vii. Procedures for reporting fraud and abuse;

viii References to Medicaid manuals, memoranda, and other related documents;

ix. Payment policies and procedures;

x. Billing instructions which are in compliance with the Department's encounter data submission requirements; and,

xi. Marketing practice guidelines and the responsibility of the provider when representing the Contractor.

b. The Contractor shall conduct education seminars and/or individual training for all providers within sixty (60) calendar days after the Contractor places a newly enrolled provider on active status. The Contractor shall also conduct ongoing training and education when deemed necessary by the Contractor or the Department.

4. Provider Payment

In accordance with Section 1932(f) of the Social Security Act (42 U.S.C. §1396a-2), the Contractor shall pay all in-and out-of-network providers on a timely basis, consistent with the claims payment procedure described in 42 C.F.R. § 447.45, Section 1902 (a)(37), upon receipt of all clean claims for covered services rendered to covered enrollees who are enrolled with the Contractor. 42 C.F.R. § 447.45 defines timely processing of claims as:

a. Adjudication (pay or deny) of ninety per cent (90%) of all clean claims within thirty (30) calendar days of the date of receipt.

b. Adjudication (pay or deny) of ninety-nine per cent (99%) of all clean claims within ninety (90) calendar days of the date of receipt.

c. Adjudication (pay or deny) all other claims within twelve (12) months of the date of receipt. (See 42 C.F.R. §447.45 for timeframe exceptions.)

This requirement shall not apply to network providers who are not paid by the Contractor on a fee-for-service basis and will not override any existing negotiated payment scheduled between the Contractor and its providers.

The Contractor must pay interest charges on claims in compliance with requirements set forth in § 38.2-4306.1 of the Code of Virginia. Specifically, interest upon the claim proceeds paid to the subscriber, claimant, or assignee entitled thereto shall be computed daily at the legal rate of interest from the date of thirty calendar days from the Contractor's receipt of "proof of loss" to the date of claim payment. "Proof of loss" means the date on which the Contractor has received all necessary documentation reasonably required by the Contractor to make a determination of benefit coverage. This requirement does not apply to claims for which payment has been or will be made directly to health care providers pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the managed care organization's obligation on such claims.

Under 1932 (b) the Contractor must establish an internal grievance procedure by which providers under contract may challenge the Contractor's decisions including, but not limited to, the denial of payment for services.

5. Provider Disenrollment

a. The Contractor must have in place written policies and procedures which are filed annually with DMAS related to provider disenrollment.

b. For PCPs, these policies and procedures shall include, but are not limited to, the following:

i. Procedures to provide a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice to each enrollee who received his or her primary care from the terminated provider. [42CFR438.10(f)(5)]

ii. Procedures to provide a good faith effort to transition PCP panel enrollees to new PCPs at least thirty (30) calendar days prior to the effective date of provider disenrollment;

iii. Procedures for the reassessment of the provider network to ensure it meets access standards established in its Contract;

iv. Procedures for notifying the Department within the time frames set forth in this contract; and

v. Procedures for temporary coverage in the case of unexpected PCP absence (e.g., due to death or illness).

c. For other network providers, these policies and procedures must address, at a minimum:

i. Procedures to provide a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice to each enrollee who received care on a regular basis by the terminated provider. [42CFR438.10(f)(5)]

ii. Procedures for notifying enrollees at least thirty (30) calendar days before the effective date of provider disenrollment;

iii. Procedures for the reassessment of the provider network to ensure it meets access standards established in this contract;

iv. Procedures for notifying the Department within the time frames set forth in this contract; and

v. Procedures for temporary coverage in case of unexpected provider absence (e.g., due to death or illness).

6. Ineligible Provider or Administrative Entities

The Contractor shall, upon obtaining information or receiving information from the Department or from another verifiable source, exclude from participation in the Contractor's plan for this Contract all provider or administrative entities which could be included in any of the following categories (references to the Act in this Section refer to the Social Security Act):

a. Entities which could be excluded under § 1128(b)(8), as amended, of the Social Security Act are entities in which a person who is an officer, director, or agent or managing employee of the entity, or a person who has direct or indirect ownership or controlling interest of five (5) percent or more in the entity has:

i. Been convicted of any of the following crimes:

1) Program related crimes, i.e., any criminal offense related to the delivery of an item or service under any Medicare, Medicaid, or other State health care program (as provided in § 1128(a)(1) of the Act, as amended);

2) Patient abuse, i.e., a criminal offense relating to abuse or neglect of a patient in connection with the delivery of a health care item or service (as provided in § 1128(a)(2) of the Act, as amended);

3) Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by Federal, State or local government (as provided in § 1128(b)(1) of the Act, as amended);

4) Obstruction of an investigation, i.e., conviction under State or Federal law of interference or obstruction of any investigation into any criminal offense described in subsections of a. b. or c (as provided in § 1128(b)(2) of the Act, as amended); or

5) Offenses relating to controlled substances, i.e., conviction of a State or Federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance (as provided in § 1128(b)(3) of the Act, as amended);

ii. Been excluded from participation in Medicare or a State health care program;

iii. Been assessed a civil monetary penalty under Section 1128A of the Social Security Act [42 U.S.C. § 1320a-7(a)-(f)]; or

(Civil monetary penalties can be imposed on an individual provider, as well as on provider organizations, agencies, or other entities, by the HHS Office of Inspector General and may be imposed in the event of false or fraudulent submittal of claims for payment and certain other violations of payment practice standards.)

iv. Been debarred, suspended, or otherwise excluded from participation in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 and 45 CFR Part 76 or under guidelines implementing such an order or is an affiliate (as defined in such Act) of a person described in clause (a).

The Contractor shall immediately notify the Department of any action taken by the Contractor to exclude, based on the provisions of this section, an entity currently participating.

b. Entities which have a direct or indirect substantial contractual relationship with an individual or entity described in Paragraph 1, above. A substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following services:

i. The administration, management, or provision of medical services;

ii. The establishment of policies pertaining to the administration, management, or provision of medical services; or

iii. The provision of operational support for the administration, management, or provision of medical services.

The Contractor attests by signing this Contract that it excludes from participation in the Contract activities all entities which could be included in the categories listed in b. i. through iii. above.

7. Physician Incentive Plan

In accordance with 42 C.F.R. § 434.70, the Contractor shall comply with 42 C.F.R. §§ 417.479(a) through (g) as amended, specifying the requirements for physician incentive plans. If the Contractor enters into subcontracting arrangements, it shall comply with 42 CFR § 417.479(i), as amended. If a physician financial arrangement is determined by the Department to potentially avoid costs by limiting referral specialty care for enrollees, the Contractor must demonstrate to the Department that all medically necessary referrals were authorized during the contract period. The Physician Incentive Plan should be submitted annually to the Department using the CMS established form.

8. Protection of Enrollee-Provider Communications

The Contractor must not prohibit or restrict a health care professional from advising a enrollee about his or her health status, medical care, or treatment, regardless of whether benefits for such are provided under the Contract, if the provider is acting within the lawful scope of practice as described in Section 4704 (b)(3) of Public Law 105-33.

9. Protected Health Information

To the extent that the Contractor uses one or more providers to render services under this Contract, and such providers receive or have access to protected health information (PHI), each such provider shall sign an agreement with the Contractor that complies with HIPAA. The Contractor shall ensure that any providers to whom it provides PHI received from the Department (or created or received by The Contractor on behalf of the Department) agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor in this Contract.

L. QUALITY IMPROVEMENT (QI)

The Contractor shall comply with 42 C.F.R. § 434.34, as amended, which requires each managed care organization which contracts with State Medicaid agencies to have an internal quality improvement program (QIP). Such QIP shall meet the accreditation standards of NCQA. The Contractor is encouraged to perform all HEDIS performance measures for the Medicaid product as a part of the QI program. In addition, the Contractor shall, at minimum, complete an asthma management quality study and the following eight HEDIS performance studies.

1. Childhood Immunization Status
2. Adolescent Immunization Status
3. Breast Cancer Screening
4. Prenatal and Postpartum Care
5. HEDIS/CAHPS 2.0H Adult Survey

6. Well-Child Visits in the First 15 Months of Life
7. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
8. Adolescent Well-Care Visit

The Contractor shall send to the Department (annually) a copy of its quality improvement program and prior year's outcomes, including results of HEDIS, and other performance measures, quality studies, and other activities as documented in the QIP. Results shall reflect completion dates.

The Contractor's QIP shall consist of systematic activities to monitor and evaluate the care delivered to enrollees according to predetermined, objective standards and to make improvements as needed. The Contractor shall correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms. The CAHPS Adult Survey report shall include detailed results for all survey items. Composite scores shall be reported using both percentages and scores based upon a three-point scale. Results of survey items asking for the number of days between the recipient's request for appointments and the recipient's actual appointment date shall be reported in the average number of days. Items that ask for ratings on an eleven-point scale (i.e., "rate your doctor on a scale of 0 to 10, with 10 being best") shall report results in the following manner: Percent scored 8 to 10; 3 to 7; and 0-2).

The QIP shall illustrate a comprehensive, integrated approach that encompasses all aspects of the health care delivery system for Medicaid/FAMIS Plus. The Contractor shall ensure that their grievance system is tied to their quality improvement program.

The Contractor shall cooperate with the Department's QIP to the extent described herein and shall, upon request, demonstrate to the Department its degree of compliance with the Department's quality standards set forth below. Additionally, the Contractor shall cooperate with the Department or its designated agent with the quality review process, including data collection and data reporting on an annual basis.

1. Quality Studies

The Contractor shall cooperate with and ensure the cooperation of network providers and subcontractors with the external review organization contracted by the Department to perform quality studies including providing timely access to recipients' medical records in the Department's requested format. The Contractor shall submit annually and upon request to the Department results of their internal quality studies.

2. Coordination and Continuity of Care

In accordance with 42 CFR §438.208, the Contractor shall have systems in place that ensure coordinated patient care for all enrollees and that provide particular

attention to the needs of enrollees with complex, serious and/or disabling conditions. The systems, policies and procedures shall be consistent with the most recent NCQA standards. Such systems shall ensure the provision of primary care services, coordinated patient care, and access when necessary to specialty care services/providers. The Contractor's coordination and continuity of care systems shall include provisions for all of the following processes:

a. Enrollees must have an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.

b. The Contractor's system to coordinate patient care must include provisions to coordinate benefits and methods to prevent the duplication of services especially with transition of care activities.

c. The Contractor shall ensure that the process utilized to coordinate the enrollee's care complies with enrollee privacy protections described in HIPAA regulations and in Title 45 CFR parts 160 and 164, subparts A and E, to the extent applicable.

d. The Contractor's pediatric and adult primary care providers and specialists must be clinically qualified to provide or arrange for the provision of appropriate health care services. The Contractor shall submit to the Department on an annual basis referral guidelines that demonstrate the conditions under which the PCPs will make the arrangements for referrals to specialty care networks.

e. The Contractor shall require their contracted providers to ensure that recipients with disabilities have effective communication with health care system participants in making decisions with respect to treatment options.

f. The Contractor shall have in place a process to develop and maintain a list of referral sources which includes community agencies, State agencies, "safety-net" providers, teaching institutions, and facilities that are needed to assure that enrollees are able to access and receive the full continuum of treatment and rehabilitative medical and outpatient mental health services and supports needed. As part of this process, MCOs shall provide discharge planning and coordination with long-term care service providers for enrollees who are being enrolled in home and community based care waivers or nursing facilities to assure continuity of care.

3. Coordination of QI Activity with Other Management Activity

The Contractor's QI findings, conclusions, recommendations, actions taken, and results of the actions taken shall be documented and reported to appropriate individuals within the Contractor's management organization and through the established QI communication channels.

QI activities shall be coordinated with other performance monitoring activities, including the monitoring of enrollees' grievances and appeals and shall reflect the most current requirements of NCQA.

4. Utilization Management/Authorization Program Description

The Contractor must have a written utilization management (UM) program description which includes procedures to evaluate medical necessity, criteria used, information source, and the process used to review and approve or deny the provision of medical services. In accordance with 42 CFR §438.210, the Contractor's UM program must ensure consistent application of review criteria for authorization decisions; and must consult with the requesting provider when appropriate. The program shall demonstrate that enrollees have equitable access to care across the network and that UM decisions are made in a fair, impartial, and consistent manner that serves the best interests of the enrollees. The program shall reflect the standards for utilization management from the most current NCQA Standards. The program must have mechanisms to detect under-utilization and/or over-utilization of care including, but not limited to, provider profiles.

The Contractor shall work with the Department and the other contracted MCOs to establish review criteria and to study the scope of underutilization for children and aged, blind, and disabled adults. The study shall be completed by February 1, 2005 and shall include the following components:

a. Identification of underutilization issues within these populations.
b. A quality improvement strategy to address the identified issues for this population.
c. A mechanism for reporting results to the Department for the issues identified.

Coverage decisions that depend upon prior authorization and/or concurrent review to determine medical necessity must be supervised by qualified medical professionals and completed within two (2) days after receipt of all necessary information. The Contractor shall use Department prior authorization criteria or other medically-sound, scientifically based criteria in accordance with national standards in making medical necessity determinations. Medical necessity criteria used by the Contractor shall be treated by the Department as proprietary information of the Contractor and shall not be subject to disclosure by the Department.

In accordance with 42 CFR §438.210, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. Additionally the Contractor and its subcontractors are prohibited from providing compensation to UM staff in a manner so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. In accordance with 42 CFR 438.210(c), the Contractor shall notify the requesting provider, and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements outlined in Article II.S. of this Contract.

The following timeframe for decision requirements apply to service authorization requests, per 42 CFR §438.210:

a. **Standard Authorization Decisions** – For standard authorization decisions, the contractor shall provide the decision notice as expeditiously as the enrollee's health condition requires, not to exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days if:

i. the enrollee or the provider requests extension; or
ii. the Contractor justifies to the Department a need for additional information and how the extension is in the enrollee's interest.

b. **Expedited Authorization Decisions**

i. For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service.

ii. The Contractor may extend the three (3) working days turnaround time frame by up to fourteen (14) calendar days if the enrollee requests an extension or the Contractor justifies to the Department a need for additional information and how the extension is in the enrollee's interest.

If the Contractor delegates (subcontracts) responsibilities for UM with a subcontractor, the Contract must have a mechanism in place to ensure that these standards are met by the subcontractor. The UM Plan shall be submitted annually to DMAS and upon revision.

The Contractor must ensure that the preauthorization requirements do not apply to emergency care, family planning services, preventive services, and basic prenatal care. Reference Article II.G.26. for provisions regarding authorizations for prescription drugs.

The Contractor (the enrollee's current MCO) shall assume responsibility for all managed care contract covered services authorized by either the Department or a previous MCO, which are rendered after the enrollment effective date, in accordance with provisions described in Article II.G.40 of this Contract.

5. Credentialing/Recredentialing Policies and Procedures

The Contractor's QIP shall contain the proper provisions to determine whether physicians and other health care professionals who are licensed by the Commonwealth and who are under contract with the Contractor or it's subcontractor(s) are qualified to perform their medical or clinical services. The Contractor shall have written policies and procedures for the credentialing process that matches the credentialing and recredentialing standards of the most recent guidelines from NCQA and in accordance with 12VAC5-408-170 of the Virginia Administrative Code. The Contractor's recredentialing process shall include the consideration of performance indicators obtained through the QIP, utilization management program, grievance and appeals system, and enrollee satisfaction surveys. The Contractor shall perform an annual review on all subcontractors to assure that the health care professionals under contract with the subcontractor are qualified to perform the services covered under this contract. The Contractor must have in place a mechanism for reporting to the appropriate authorities any actions that seriously impact quality of care and which may result in suspension or termination of a practitioner's license.

6. Practice Guidelines

The Contractor shall establish practice guidelines as described in this section, and that are congruent with current NCQA Standards.

a. Adoption of Practice Guidelines

In accordance with 42 CFR 438.236, the Contractor shall adopt practice guidelines that meet the following requirements:

i. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

ii. Consider the needs of the enrollees;

iii. Are adopted in consultation with contracting health care professionals; and

iv. Are reviewed and updated periodically, as appropriate.

b. Dissemination of Guidelines

The Contractor shall disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. Additionally, the Contractor shall provide a copy of its practice guidelines to the Department on an annual basis.

c. Application of Guidelines

Contractor decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.

7. Monitoring and Evaluation of Enrollee Grievances and Appeals

The Contractor shall have in place a mechanism to link its enrollee grievances and appeals system, as set forth in Article II, to the QIP and credentialing process.
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The Contractor shall, at a minimum, track trends in grievances and appeals and incorporate this information into the QI process. The Contractor's appeals and grievances system shall be consistent with Federal and State regulations and the most current NCQA standards.

8. Department Oversight

The Department reserves the right to review the Contractor's policies and procedures and determine conditions for formal notification to the Department of situations involving quality of care.

9. Notification to the Department of Sentinel Events

a. The Contractor shall maintain a system for identifying and recording the following sentinel event:

i. Recipient death

b. At a minimum, the following information must be documented on each sentinel event:

i. Recipient full name;

ii. Recipient Medicaid/FAMIS Plus ID Number;

iii. Recipient's PCP's name;

iv. Recipient's cause of death and the providers involved;

v. Date of occurrence; and

vi. Source of sentinel event data.

c. The Contractor shall provide the Department or its Agent with reports of sentinel events monthly via the Sentinel Event Reporting Form, Attachment XIV.

M. MEDICAL RECORDS

The Contractor shall have a requirement of all network providers that medical records will be maintained in paper or electronic form for all enrolled enrollees. The Contractor shall require compliance of all providers and subcontractors with HIPAA security and confidentiality of records standards, as detailed in Article IX of this Contract. Additionally, the Contractor shall maintain standards for medical records that are congruent with current NCQA guidelines. The requirements shall:

a. Include written policies to ensure that medical records are safeguarded against loss, destruction, or unauthorized use. The Contractor shall have written procedures for release of information and obtaining consent for treatment.

b. Include procedures maintained by the Contractor or maintained by network provider(s) so that individual medical records for each enrollee are made readily available to the Department, the contracted External Quality Review Organization (EQRO), and to appropriate health professionals. Procedures shall also exist to provide for prompt transfer of records to other in- or out-of-network providers for the medical management of the enrollee. The Contractor shall use its best efforts to assist enrollees and their authorized representatives in obtaining records within ten (10) business days of the record request. The Contractor will identify an individual who can assist enrollees and their authorized representatives in obtaining records. The Contractor shall use its best efforts, when an enrollee changes PCPs, to assure that his or her medical records or copies of medical records are made

available to the new PCP within ten (10) business days from receipt of request from the enrollee.

c. Include procedures to assure that medical records are readily available for the Department, its contracted quality assurance oversight provider, Contractor-wide quality assurance and utilization review activities and provide adequate medical and other clinical data required for quality improvement, utilization management, encounter data validation, and payment activities. Specifically, the Contractor shall use its best efforts to ensure that all medical records are provided within the greater of the amount of time, if specified in the request or twenty (20) business days. The Department shall be afforded access within twenty (20) calendar days to all enrollees' medical records, whether electronic or paper. Access shall be afforded within ten (10) calendar days upon request for a single record or a small volume of records. The Contractor may be given only a partial list of records required for on-site audits with no advance list of records to be reviewed or one (1) week's notice, with the remaining list of records presented at the time of audit.

d. Provide for adequate information and record transfer procedures to provide continuity of care when enrollees are treated by more than one provider.

N. FINANCIAL MANAGEMENT

The Contractor shall establish and maintain a financial management capability sufficient to ensure that the requirements of Article II, Part A are met.

O. MANAGEMENT INFORMATION SYSTEMS

The Contractor must have in place management information systems capable of furnishing the Department with timely, accurate, and complete information about the Medallion II program. Such information systems shall:

a. Accept and process enrollment reports and reconcile them with the MCO enrollment/eligibility file;

b. Accept and process provider claims and encounter data, as set forth in this Contract;

c. Track provider network composition and access, and grievances and appeals as set forth in this Contract;

d. Perform quality improvement activities, as set forth in this Contract;

e. Furnish the Department with timely, accurate and complete clinical and administrative information, as set forth in this Contract;

f. Ensure that data received from providers is accurate, and complete by:

i. Verifying the accuracy and timeliness of reported data;

ii. Screening the data for completeness, logic, and consistency;

iii. Collecting service information in standardized formats as set forth in this Contract; and

g. In accordance with requirements set forth in 1932(d)(4) and 1173(b)(2) of the Social Security Act, the Contractor must assign unique identifiers to providers, including physicians, and must require that providers use these identifiers when submitting data to the contractor.

P. ELECTRONIC DATA SUBMISSION INCLUDING ENCOUNTER CLAIMS

The Contractor may not transmit protected health information (PHI) over the Internet or any other insecure or open communication channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent that those described in 45 CFR § 142.308(d).

If the Contractor stores or maintains PHI in encrypted form, the Contractor shall, promptly at the Department's request, provide the Department with the software keys to unlock such information.

1. Electronic Data Interchange (EDI)

Each party will transmit documents directly or through a third party value added network. Either party may select, or modify a selection of, a Value-Added Network (VAN) with thirty (30) days written notice.

Each party will be solely responsible for the costs of any VAN with which it contracts. Each party will be liable to the other for the acts or omissions of its VAN while transmitting, receiving, storing or handling documents. Each party is solely responsible for complying with the subscription terms and conditions of the VAN he or she selects, and for any and all financial liabilities resulting from that subscription agreement.

2. Test Data Transmission

Each party agrees to actively send and receive test data transmissions until approved. Supplier agrees to receive redundant transmission (e.g. faxed copy and

electronic), if required by the Department, for up to thirty (30) days after a successful EDI link is established.

3. Garbled Transmissions

If a party receives an unintelligible document, that party will promptly notify the sending party (if identifiable from the received document). If the sending party is identifiable from the document but the receiving party failed to give notice that the document is unintelligible, the records of the sending party will govern. If the sending party is not identifiable from the document, the records of the party receiving the unintelligible document will govern.

4. Certification

Any payment information from the contractor that is used for rate setting purposes (e.g. any encounter data) or any payment related data required by the state must be certified by the contractor's Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer of the contractor.

The contractor must use Attachment XXIII, Certification of Encounter Data, on a quarterly basis reflecting prior submissions of encounters; and, Attachment XXIV, Certification of Data, for certification of non-encounter payment related data submissions within one (1) week of the date of submission.

5. Enforceability and Admissibility

Any document properly transmitted pursuant to this Agreement will be deemed for all purposes (1) to be a "writing" or "in writing," and (2) to constitute an "original" when printed from electronic records established and maintained in the ordinary course of business. Any document which is transmitted pursuant to the EDI terms of this Agreement will be as legally sufficient as a written, signed, paper document exchanged between the parties, notwithstanding any legal requirement that the document be in writing or signed. Documents introduced as evidence in any judicial, arbitration, mediation or administrative proceeding will be admissible to the same extent as business records maintained in written form.

6. Timeliness, Accuracy, and Completeness of Data

The Contractor must ensure that all electronic data submitted to the Department are timely, accurate and complete. At a minimum, encounter data and provider rosters will be submitted via electronic media.

In the event that electronic provider files are returned to the Contractor due to errors, the Contractor agrees to process incorrect data and resubmit within five (5) business days. All other electronic data returned for errors must be corrected and resubmitted within thirty (30) days. The Contractor agrees to correct encounter

claims where appropriate and resubmit corrected encounter claims in accordance with the specifications set forth in this subsection.

7. Encounter Claims Data Submission

All encounters shall be submitted using the nationally recognized formats defined below:

- Hospital, Professional, and Dental Claims – Submit using the American National Standards Institute (ANSI) 837, version 40.10 with addenda.
- Pharmacy Claims – Submit using the National Council for Prescription Drug Programs (NCPDP) Batch Version 1.1.

All encounters must be submitted to the Virginia Medicaid Management Information System (VAMMIS) Gateway System to interface with the First Health File Transfer Protocol (FTP) Server.

Submissions must be made at least monthly and may be made more frequently with the approval of the Department. Files with HIPAA defined level 1 or level 2 errors in the ISA, GS, GE, or ISE records will be rejected and a negative 997 sent back to the submitter. The entire file must be resubmitted after the problem is fixed. Files with HIPAA defined level 1 or level 2 errors inside a ST-SE loop will have that ST-SE loop rejected and a negative 997 will be sent back to the submitter identifying the loop. Any other ST-SE loops, which do not have level 1 or level 2 errors, will be processed. Only the rejected ST-SE loops should be resubmitted after fixing the problem. Errors on rejected files or ST-SE loops must be corrected and resubmitted within thirty (30) days of the date.

For the purposes of this Contract, an encounter is any service received by the enrollee and processed by the Contractor. The Contractor shall submit encounters/claims for all services it covers including, but not limited to, inpatient and outpatient procedures, EPSDT screens, transportation, pharmacy, durable medical equipment (DME), and home health care services. The Contractor is responsible for submission of data from all of its subcontractors to the State or its agent in the specified format and on a timely basis.

Except for encounters involving appeals, the Contractor shall submit to the Department ALL electronic encounter claims within one hundred eighty (180) calendar days of receipt or within one hundred eighty (180) calendar days of inpatient discharge. Late data will be accepted, but the Department reserves the right to set and adjust timeliness standards as required in order to comply with State and Federal reporting requirements. The Contractor is strongly encouraged to submit encounter data as received and discouraged from waiting the full time allotted before submitting the encounter data to the Department. The Department reserves the right to require written explanations of all appeals.

8. Encounter Data Reconciliation

The Contractor shall fully cooperate with all DMAS efforts to monitor the Contractor's compliance with the requirements of encounter data submission including encounter data accuracy, completeness, and timeliness of submission to the DMAS Fiscal Agent. The Contractor shall comply with all requests related to encounter data monitoring efforts in a timely manner.

Q. REPORTING REQUIREMENTS

The Contractor shall establish and maintain all necessary systems, policies and procedures to fulfill the reporting requirements in Attachment VII to this Contract. The encounter data aspects of these requirements shall conform to the nationally recognized standard (ANSI or NCPDP) currently in use by DMAS. The Department reserves the right to change/modify these requirements as is necessary to meet State and Federal (including HIPAA) reporting requirements.

The Contractor shall submit the Managed Care Monthly Report (See attachment XVI.) no later than the 15th of the month following the month of reporting. The Contractor shall submit the Disproportionate Share Hospital Report (See attachment VIII.) within thirty (30) days from the end of each quarter.

The Contractor shall comply with State and Federal (42 CFR Part 441 Subpart F as amended) reporting and compliance requirements for sterilizations and hysterectomies, reporting the policy and processes used to monitor compliance to the Department annually.

The Contractor shall submit an organizational chart annually that outlines the Medallion II operating division within its plan. The organizational chart should include all divisions that handle Medallion II (claims, member services, outreach/marketing, health services, etc.).

The Contractor shall submit annually an updated company background history that includes any awards, major changes or sanctions imposed since the last annual report. The Contractor shall also submit the same information for all of its subcontractors.

R. CHILDREN WITH SPECIAL HEALTH CARE NEEDS

1. Identification

Children with Special Health Care Needs (CSHCN) include children under age 21 who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age. CSHCN consist of children in the eligibility category of SSI participation.

The Department shall provide to the Contractor a monthly report identifying all SSI children to enable the Contractor to identify and better serve CSHCN.

2. Assessment and Referral

In accordance with 42 CFR 438.208 (c), the Contractor shall make a good faith effort to conduct an assessment of all CSHCN, as identified and reported by the Department, within 90 days receipt of notification SSI children. The Contractor shall provide, on an annual basis, to the Department a copy of the detailed policies and procedures for completion of assessments of Contractor's assessment mechanism must utilize appropriate health care professionals and must identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.

The Contractor shall assess the quality of care of CSHCN in the following areas:

i. Program Development – Involve stakeholders, advocates, providers, and/or consumers, as applicable, in creating a program to support families of children with disabilities.

ii. Enrollment Procedures – Identify and collect data on children with special needs through surveys to assess the quality, appropriateness of, experience of, and satisfaction with care provided to children and adolescents with special health care needs.

iii. Provider Networks – Assure the availability of providers who are experienced in serving children with special needs and provide a "medical home" that is accessible, comprehensive, coordinated, and compassionate.

iv. Care Coordination – Provide care coordination for CSHCN among the multiple providers, agencies, advocates, and funding sources serving CSHCN. (Reference Article II.G.38)

v. Access to Specialists – The Contractor shall have a mechanism in place for recipients determined to have ongoing special conditions that require a course of treatment or regular care monitoring, that allows the enrollee direct access to a specialist through a standing referral or an approved number of visits as appropriate for the enrollee's condition and identified needs.

3. Assurance of Expertise for Child Abuse and Neglect and Domestic Violence

The Contractor shall arrange for the provision of examination and treatment services by providers with expertise, capability, and experience in dealing with

the medical/psychiatric aspects of caring for victims and perpetrators of child abuse, neglect, and domestic violence. Such expertise and capability shall include the ability to identify possible and potential victims of child abuse, neglect, and domestic violence and demonstrated knowledge of statutory reporting requirements and local community resources for the prevention and treatment of child abuse and neglect and domestic violence. The Contractor shall include such providers in its network. The Contractor shall utilize human services agencies or appropriate providers in their community.

The Contractor shall notify all persons employed by or under contract to it who are required by law to report suspected child abuse and neglect and ensure they are knowledgeable about the law and about the identification requirements and procedures. The Contractor assures that providers with appropriate expertise and experience in dealing with perpetrators and victims of domestic abuse and incest are utilized in service provision.

S. ENROLLEE NOTICES, GRIEVANCES, AND APPEALS PROCEDURES

The Contractor shall have a system in place to respond to inquiries, grievances, appeals, and claims received from enrollees. Additionally, the Contractor shall ensure that enrollees are sent written notice of any adverse action (as defined in 2.a. below) which informs enrollees of their right to appeal through the MCO as well as their right to access the Department's State fair hearing system. The Contractor shall provide to all network providers and subcontractors information about the grievance and appeals systems to the specifications described in 42 CFR 438.10(g)(1) (described in Article II.D.18 of this Contract) at the initiation of all such contracts.

1. Inquiries/Claims Filed By Enrollees

For the purposes of this Contract, an inquiry is an oral or written communication made by or on the behalf of a member that includes questions/comments about eligibility, benefits, plan requirements, materials received, change in address/family composition, PCP assignment, translation services, how to access services, etc. Inquiries are not expressions of dissatisfaction. The Contractor shall provide a timely response to all inquiries received from enrollees or on behalf of enrollees while ensuring HIPAA compliance.

Additionally, in any instance where the Contractor receives a claim for payment filed by the enrollee, the Contractor shall respond to the enrollee, in writing, and at the time of any action affecting the claim. This response to the enrollee is required regardless of any response that the Contractor sends to the provider of service. The response shall inform the enrollee regarding approval or denial of coverage and shall detail any further action that is required in order to process the claim.

2. Notice of Adverse Action Process

The Contractor shall notify the requesting provider and shall provide written notice to enrolled (on the date of service) members whenever rendering an adverse decision. The contractor has the option to send the enrollee notice as an explanation of benefits statement or as a notice of adverse action. Any statement or notice must be in accordance with the definitions, content of notice, and required timeframes listed below.

a. **Definition of Adverse Action** – Consistent with 42 CFR § 438.400, action refers to the:

i. denial or limited authorization of a service authorization request; including the type or level of service; or

ii. reduction, suspension, or termination of a previously authorized (as defined in Article I) service; or

iii. denial in whole or in part of a payment for a covered service for an enrolled member (except where the provider's claim is denied for technical reasons including but not limited to prior authorization rules, referral rules, late filing, invalid codes, etc); or

iv. failure by the Contractor to render a decision within the timeframes required in Article II.L and Article II.S of this Contract; or

v. The denial of an enrollee's request to exercise his right under 42 CFR 438.52(b)(2)(ii) to obtain services outside of the network.

b. **Content of Notice**

The notice must be in writing and must meet the language and format requirements described in 42 CFR § 438.10. (See Article II.F. of this contract.) The notice must explain the following:

i. The action taken and the reasons for the action,

ii. The enrollee's right to file an appeal with the MCO,

iii. The enrollee's right to request a State fair hearing in accordance with 12VAC30-110-10 through 12VAC30-110-380 and as described in this section,

iv. The procedures for exercising appeal rights,

v. The circumstances under which expedited resolution is available and how to request an expedited resolution, and

vi. The circumstances under which the enrollee has the right to request that benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services. (Reference the "Continuation of Benefits" described in this subsection.)

c. Timing of Notice

The Contractor must mail the notice within the following timeframes:

i. For termination, suspension, or reduction of previously authorized services, the notice must be issued at least ten (10) days prior to the effective date of the intended adverse action, as required in 42 CFR § 431 Subpart E.

ii. For denial of payment, the notice must be issued in accordance with Article II.S.2.a.iii. at the time of action affecting the claim.

iii. For standard service authorization decisions that deny services, the notice must be issued within the timeframes specified in 438.210(d) as described in Article II.L. of this Contract.

iv. For standard service authorization decisions that extend the review timeframe in excess of the standard fourteen (14) days, the Contractor must mail the written notice no later than the 14th day to the enrollee, describing the reason for the decision to extend the timeframe and informing the enrollee of the right to file a grievance if he or she disagrees with that decision. Additionally, the Contractor must issue and carry out the review for the final determination as expeditiously as the enrollee's health condition requires and shall not exceed the date on which the extension expires.

v. For service authorization decisions not reached within the required timeframes specified in Article

II.L. of this Contract, in accordance with 42 CFR § 438.210(d) (which constitutes a denial and is thus an adverse action), the notice must be issued on the date that the established timeframes for review expire.

vi. For expedited service authorization decisions, the notice must be issued as expeditiously as the enrollee's health condition requires, not to exceed three (3) working days after receipt of the request for service.

vii. For expedited service authorization decisions where the Contractor has extended the three (3) working days turnaround time frame in accordance with Article II.L.4.b., as expeditiously as the enrollee's health condition requires, not to exceed the date on which the extension expires.

3. General Policies and Procedures for Grievances and Appeals

The Contractor shall have written policies and procedures that describe the grievance and appeals process and how it operates; and the process must be in compliance with 12 VAC 30-120-420, as amended. These written directives shall describe how the Contractor intends to receive, track, review, and report all enrollee inquiries, grievances and appeals. The Contractor shall make any changes to its enrollee grievance and appeal procedures that are required by the Department. The procedures and any changes to the procedures must be submitted to the Department annually.

The Contractor shall provide grievance and appeal forms and/or written procedures to enrollees who wish to register written grievances or appeals. Additionally, the Contractor shall provide reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. The procedures must provide for prompt resolution of the issue and involve the participation of individuals with the authority to require corrective action. Specific requirements regarding enrollee notices, grievances, and appeals are contained in this Article.

The grievance and appeals processes must be integrated with the Contractor's QIP. The grievance and appeals process shall include the following:

i. Procedures for registering and responding to grievances and appeals in a timely fashion;

ii. Documentation of the substance of the grievance or appeal and the actions taken;

iii. Procedures to ensure the resolution of the grievance or appeal in accordance with the requirements outlined in this Contract; and

iv. Aggregation and analysis of these data and use of the data for quality improvement.

The Contractor must maintain a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision. This system shall distinguish Medallion II from commercial enrollees if the Contractor does not have a separate system for Medallion II enrollees.

4. Grievance Procedures

A grievance is defined as an expression of dissatisfaction about any matter other than an "action" as "action" is defined in this Contract. The Contractor's grievance process must allow the enrollee, or the enrollee's authorized representative (provider, family member, etc.) acting on behalf of the enrollee, to file a grievance either orally or in writing. The Contractor shall acknowledge receipt of each grievance. (Grievances received orally can be acknowledged orally.) The Contractor shall also ensure that the individuals who make decisions on grievances were not involved in any previous level of review or decision making. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, the Contractor shall ensure that the decision-makers are health care professionals with the appropriate clinical expertise in treating the enrollee's condition or disease. [42 CFR § 438.406]

The Contractor must respond to all grievances as expeditiously as the enrollee's health condition requires, not to exceed 30 (thirty) days from the date of initial receipt of the grievance. Grievances that are received telephonically may be responded to in-kind, and need not be followed-up with a written response, unless one is requested by the enrollee or the enrollee's authorized representative.

The grievance response shall include, but not be limited to, the decision reached by the Contractor; the reason(s) for the decision; the policies or procedures which provide the basis for the decision; and a clear explanation of any further rights available to the enrollee under the Contractor's grievance process.

5. Appeals Process and Standard and Expedited Reviews

Enrollees have the right to appeal any adverse "action" issued by the Contractor, the Contractor's subcontractors or providers. The Contractor must accept appeals submitted within thirty (30) days from the date of notice of adverse action.

a. **Appeals Process** - The Contractor's appeals process must include the following requirements:

i. Allow the enrollee, or enrollee's authorized representative (requires written consent from the enrollee) acting on behalf of the enrollee to file an appeal either orally or in writing and unless he or she requests an expedited resolution, must follow an oral filing with a written, signed, appeal.

ii. Acknowledge receipt of each appeal.

iii. Ensure that the individuals who make decisions on appeals were not involved in any previous level of review or decision making.

iv. Ensure that the individuals who, if deciding on any of the following, are health care professionals with the appropriate clinical expertise in treating the enrollee's condition or disease.

a. An appeal of a denial that is based on lack of medical necessity.
b. An appeal that involves clinical issues.

v. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing unless the enrollee or the provider appealing on the enrollee's behalf requests expedited resolution.

vi. Provide the enrollee a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The Contractor must inform the enrollee of the limited time available for this, especially in the case of expedited resolution.)

vii. Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including any medical records and any other documents and records considered during the appeals process.

viii. Include as parties to the appeal the enrollee and his or her representative or the legal representative of a deceased enrollee's estate.

ix. Continue benefits while the Contractor's appeal or the State fair hearing is pending, in accordance with 42 CFR § 438.420, when **all** of the following criteria are met:

a. The enrollee or the provider on behalf of the enrollee files the appeal within ten (10) days of the Contractor's mail date of the notice of adverse action or prior to the effective date of the Contractor's notice of adverse action; and

b. The appeal involves the termination, suspension, or reduction of a previously authorized (as defined in Article I) course of treatment; and

c. The services were ordered by an authorized provider; and

d. The original period covered by the initial authorization has not expired; and

e. The enrollee requests extension of benefits.

If the final resolution of the appeal is adverse to the enrollee, that is, the Contractor's adverse action is upheld, the Contractor may pursue recovery of the cost of services furnished to the enrollee while the appeal was pending, to the extent that the services were furnished solely because of the requirements listed above, and in accordance with the policy described in 42 CFR §§ 431.230(b) and 438.420.

b. Standard Resolution

The Contractor shall respond in writing to standard appeals as expeditiously as the enrollee's health condition requires and shall not exceed thirty (30) days from the initial date of receipt of the appeal. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the enrollee requests the extension or if the Contractor provides evidence satisfactory to the Department that a delay in rendering the decision is in the enrollee's interest. For any appeals decisions not rendered within thirty (30) days where the enrollee has not requested an extension, the Contractor shall provide written notice to the enrollee of the reason for the delay.

For any appeal decision that is pending the receipt of additional information, the Contractor shall issue a decision within no more than 45 days from the initial date of receipt of the appeal.

c. Expedited Resolution

The Contractor shall establish and maintain an expedited review process for appeals where either the Contractor or the enrollee's provider determines that the time expended in a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. The Contractor shall ensure that punitive action is neither taken against a provider that requests an expedited resolution nor supports an enrollee's appeal. In instances where the enrollee's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not to exceed three (3) working days from the initial receipt of the appeal. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the enrollee requests the extension or if the Contractor provides evidence satisfactory to the Department that a delay in rendering the decision is in the enrollee's interest. For any extension not requested by the enrollee, the Contractor shall provide written notice to the enrollee of the reason for the delay. The Contractor shall make reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up within two calendar days with a written notice of action.

All decisions to appeal must be in writing and shall include, but not be limited to, the following information:

i. The decision reached by the Contractor;

ii. The date of decision;

iii. For appeals not resolved wholly in favor of the enrollee

a. The right to request a State fair hearing and how to do so;

b. The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the Contractor.

6. State Fair Hearing Process

The Contractor shall educate its enrollees of their right to appeal directly to the Department. The enrollee has the right to appeal to the Department at the same time that he appeals to the Contractor; or after he has exhausted his appeal rights with the Contractor; or instead of appealing to the Contractor. Any adverse action or appeal that is not resolved wholly in favor of the enrollee by the Contractor may be appealed by the enrollee or the enrollee's authorized representative to the Department for a fair hearing conducted in accordance with 42 CFR § 431 Subpart E and the Department's Client Appeals regulations at 12 VAC 30-110-10, et. seq.

If an enrollee wishes to file an appeal with the Department, the appeal must be filed in writing within thirty (30) days of the enrollee's receipt of notice of any action to deny, delay, terminate, or reduce a service authorization request; or to deny payment for Medicaid/FAMIS Plus covered services unless good cause exists.

Good cause shall include, but not be limited to, situations or events where:

i. Appellant was seriously ill and was prevented from contacting the Contractor;

ii. Appellant did not receive notice of the Contractor's decision;

iii. Appellant sent the request for appeal to another government agency in good faith within the time limit; or

iv. Unusual or unavoidable circumstances prevented a timely filing.

If the Contractor's notice is "defective," i.e., does not contain the required elements, good cause may exist.

For enrollee appeals through the Department's Appeals Division, the Contractor is responsible for providing to the Department and to the enrollee an appeal summary describing the basis for the denial in accordance with 12 VAC 30-110-70. For standard appeals, the appeal summary must be submitted to the Department and the enrollee at least ten (10) days prior to the date of the hearing. For expedited appeals, (that meet the criteria set forth in 42 CFR § 438.410) the appeal summary must be faxed to the Department and faxed or overnight mailed to the enrollee, as expeditiously as the enrollee's health condition requires, but no later than 4 business hours after the Department informs the Contractor of the expedited appeal. The Department may require that the MCO attend the hearing either via telephone or in person. The MCO is responsible for absorbing any telephone/travel expenses incurred.

The Contractor shall comply with the Department's hearing process, no more or less and in the same manner as is required for all other Medicaid/FAMIS Plus evidentiary hearings. The Contractor shall comply with the Department's fair hearing decision. The Department's decision in these matters shall be final and shall not be subject to appeal by the Contractor.

7. Reversed Appeal Resolutions

In accordance with 42 CFR §438.424, if the Contractor's or the State fair hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, the Contractor must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires. Additionally, in the event that services were continued while the appeal was pending, the Contractor must provide reimbursement for those services in accordance with the terms of the final decision rendered by the Department's Appeals Division and with the terms of this contract and applicable regulations.

8. Contractor Grievance and Appeal Reporting

The Contractor shall submit to the Department by the fifteenth (15th) day of the month after the end of each month, a mutually agreed upon summary report of inquires, grievances and appeals as illustrated in Attachment VI.

The Contractor shall also submit to the Department by the fifteenth (15) day of the month after the end of each month a log of grievances and appeals filed by enrollees under this Contract.

a. Grievance and appeal categories identified shall be organized or grouped by the following general guidelines:

   i. Access to Health Services

   ii. Utilization and Medical Management Decisions

   iii. Provider Care and Treatment

   iv. Payment and Reimbursement Issues

   v. Administrative Issues

b. The log shall contain the following information for each grievance or appeal:

   i. The date of the communication;

ii. The enrollee's Medicaid/FAMIS Plus identification number;

iii. Whether the grievance or appeal was written or oral;

iv. Indication of whether the dissatisfaction was a grievance or an appeal;

v. The category, specified in subsection a, of each inquiry;

vi. A description of subcategories or specific reason codes for each grievance and appeal. Attachment XIII contains illustrative examples of subcategories or specific reason codes;

vii. The resolution; and

viii. The resolution date.

The Contractor may use reports from its existing Member Services system if the system meets the above-stated Department criteria.

T. DATA CERTIFICATIONS AND PROGRAM INTEGRITY

1. Data Certifications

a. Data Requiring Certification

i. In accordance with 42 CFR §438.604 and §438.606, any payment information from the contractor that is used for rate setting purposes, any encounter data, or any payment related data required by the state must be certified by the contractor's Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer of the contractor. The certifications shall attest that the contractor has reviewed the encounter data or other information and attests, based on best knowledge, information, and belief as of the date signed and submitted that it is accurate, complete and truthful.

The contractor must use Attachment XXIII, Certification of Encounter Data, on a quarterly basis reflecting prior submissions of encounters; and, Attachment XXIV, Certification of Data, for certification of non-encounter payment related data submissions within one (1) week of the date of submission.

b. Source, Content, and Timing of Certification

i. Source of Certification – Data as specified in this section must be certified by one of the following individuals: the Contractor's Chief Executive Officer (CEO); Chief Financial Officer (CFO); or other individual with delegated authority to sign for and reports directly to the Contractor's CEO or CFO.

ii. Content of Certification – The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data submitted.

iii. Timing of Certification – The Contractor must submit the certification concurrently with each submission.

2. Program Integrity Requirements

The Contractor must have in place policies and procedures for ensuring protections against actual or potential fraud and abuse. The Contractor must have a detailed Program Integrity Plan. The Program Integrity Plan must define how the Contractor will adequately identify and report suspected fraud and abuse by enrollees, by network providers, by subcontractors and by the Contractor. The Program Integrity Plan must be submitted annually and must discuss the monitoring tools and controls necessary to protect against theft, embezzlement, fraudulent marketing practices (Reference Article II.C.3. of this Contract.), or other types of fraud and program abuse and describe the type and frequency of training that will be provided to detect fraud. All fraudulent activities or other program abuses shall be subject to the laws and regulations of the Commonwealth of Virginia and/or Federal laws and regulations.

In accordance with 42 CFR §438.608, the Contractor's Program Integrity Plan must address the following requirements:

a. Written Policies and Procedures

The Contractor shall develop written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable Federal and State Standards for the prevention, detection and reporting of incidents of potential fraud and abuse by enrollees, by network providers, by subcontractors and by the Contractor. As required in 42 CFR § 455.1, the Contractor's Program Integrity Plan must include a method to verify whether services reimbursed were actually furnished to the member.

b. Compliance Officer

The Contractor shall designate a compliance officer and a compliance committee, accountable to senior management, to coordinate with the Department on any fraud or abuse case. The Contractor may identify different contacts for enrollee fraud and abuse, network provider fraud and abuse, subcontractor fraud and abuse, and Contractor fraud and abuse.

c. Training and Education

The Contractor shall establish effective program integrity training and education for the Compliance Officer and all Contractor staff.

d. Effective Lines of Communication Between Contractor Staff

The Contractor shall establish effective lines of communication between the compliance officer and other Contractor staff.

e. Well-Publicized Disciplinary Guidelines

The Contractor shall enforce program integrity standards through well-publicized disciplinary guidelines.

f. Internal Monitoring and Audit

The Contractor shall establish and implement provisions for internal monitoring and auditing.

g. Process for Reporting Potential or Actual Fraud and Abuse

The Contractor shall provide information and a procedure for enrollees, network providers and subcontractors to report incidents of potential or actual fraud and abuse to the Contractor and to the Department.

h. Prompt Response to Reported Offenses

The Contractor shall report all potential or actual fraud and abuse to the Department.

i. Development of Corrective Action Initiatives

The Contractor's Program Integrity Plan shall include provisions for corrective action initiatives.

j. Time Frame for Reporting Fraud and Abuse to the Department

The Contractor shall report incidents of potential or actual fraud and abuse to the Department within forty-eight (48) hours of initiation of any investigative action by the Contractor or within forty-eight (48) hours of Contractor notification that another entity is conducting such an investigation of the Contractor, its network providers, or its enrollees.

The Contractor shall report all incidents of potential or actual marketing services fraud and abuse immediately (within 48 hours of discovery of the incident). All reports shall be sent to the Department in writing and shall include a detailed account of the incident, including names, dates, places, and suspected fraudulent activities.

k. Cooperation with State and Federal Investigations

The Contractor shall cooperate with all fraud and abuse investigation efforts by the Department and other State and Federal offices.

U. ACCESS TO AND RETENTION OF RECORDS

In addition to the requirements outlined below, the Contractor must comply, and must require compliance by its subcontractors and providers, with HIPAA security and confidentiality of records standards, detailed in Article IX of this Contract.

1. Access to Records

The Department and its duly authorized representatives shall have access to any books, fee schedules, documents, papers, and records of the Contractor and any of its subcontractors or network providers.

The Department, or its duly authorized representatives, shall be allowed to inspect, copy, and audit any medical and/or financial records of the Contractor, its subcontractors and its network providers.

2. Retention of Records

All records and reports relating to this Contract shall be retained by the Contractor for a period of six (6) years after final payment is made under this Contract or in the event that this Contract is renewed, six (6) years after the renewal date. When an audit, litigation or other action involving records is initiated prior to the end of said period, however, records shall be maintained for a period of six (6) years following resolution of such action. Copies on microfilm or other appropriate media of the documents contemplated herein may be substituted for the originals provided that the microfilming or other duplicating procedures are reliable and are supported by an effective retrieval system which

meets legal requirements to support litigation, and to be admissible into evidence in any court of law.

V. ACCESS TO PREMISES

The Contractor shall allow duly authorized agents or representatives of the State or Federal Government, during normal business hours, access to the Contractor's premises, subcontractor's premises, or the premises of the Contractor's network providers to inspect, audit, monitor or otherwise evaluate the performance of the Contractor, subcontractor, or network provider's contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event "right of access" is requested under this section, the Contractor, subcontractor, or network provider shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Contractor's or subcontractor's activities. The Contractor will be given thirty (30) calendar days to respond to any preliminary findings of an audit before the Department shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

The Department, the Office of the Attorney General of the Commonwealth of Virginia, the Federal Department of Health and Human Services, and/or their duly authorized representatives shall be allowed access to evaluate, through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract.

W. ANNUAL AUDIT BY INDEPENDENT AUDITOR

The Contractor shall provide the Department with a copy of its annual audit report required by the Bureau of Insurance at the time it is submitted to the Bureau of Insurance. The Department reserves the right to require the Contractor to engage the services of an outside independent auditor to conduct a general audit of the Contractor's major managed care functions performed on behalf of the Commonwealth. The Contractor shall provide the Department a copy of such an audit within thirty (30) calendar days of completion of the audit.

X. CONFLICT OF INTEREST

Nothing in this Contract shall be construed to prevent the Contractor from engaging in activities unrelated to this Contract, including the provision of health services to persons other than those covered under this Contract, provided, however, that the Contractor furnishes the Department with full prior disclosure of such other activities.

Y. NON-DISCRIMINATION

The Contractor shall comply with all applicable Federal and State laws relating to non-discrimination and equal employment opportunity and assure physical and program accessibility of all services to persons with physical and sensory disabilities pursuant to § 504 of the Federal Rehabilitation Act of 1973, as amended (29 U.S.C. 794), and with all requirements imposed by applicable regulations in 45 C.F.R. Part 84, Title VI of the Civil Rights Act, the Americans with Disabilities Act, the Age Discrimination and Employment Act of 1967, and the Age Discrimination Act of 1975. In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability or national origin. The Contractor shall comply with the provisions of Executive Order 11246, "Equal Employment Opportunity," as amended by Executive Order 11375 and supplemented in the United States Department of Labor regulations (41 C.F.R. 60).

The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the Contractor setting forth the provisions of the non-discrimination clause.

Z. COMPLIANCE WITH APPLICABLE LAWS AND REGULATIONS

The Contractor shall observe and comply with all Federal [(including the Health Insurance Portability and Accountability Act of 1996 (HIPAA)] and State laws and regulations in effect when the Contract is signed or which may come into effect during the term of the Contract which in any manner affect the Contractor's performance under this Contract.

In case of contract disputes, these documents will be reviewed and considered in the order shown to resolve said disputes:

a. Federal Regulations
b. Virginia State Plan
c. Medallion II Waiver
d. Medallion II State Regulations
e. Medallion II Contract, including all amendments, attachments, and Medicaid memos and manuals.

ARTICLE II (a) - FUNCTIONS AND DUTIES OF THE CONTRACTOR IN AREAS WHERE MEDALLION II IS OPERATING WITH ONLY ONE (1) CONTRACTED MANAGED CARE ORGANIZATION

All functions and duties as reflected in Article II (see prior section) shall apply to the MCO except for Article II.D.4. –6. and 18.c.i. The Sections below shall apply in instances where Medallion II is operating with only one (1) contracted MCO.

D. ELIGIBILITY AND ENROLLMENT

4. Preassignment to MCO or Department's PCCM Program

Clients will be preassigned as follows:

a. All eligible persons, except those meeting one of the exclusions of Article II, D., 2 shall be enrolled in Medallion II.

b. Once individuals are enrolled in Medicaid/FAMIS Plus, they will receive a letter indicating that they may select the contracted MCO or the Department's PCCM provider participating in the client's area of residence. The letter shall indicate the MCO or PCCM provider to which the enrollee will be enrolled if he/she does not make a selection within a designated time period. Enrollees are encouraged to exercise their choice.

c. Temporary Exception to Medallion II Enrollment

(1) Enrollees under age 21 will be eligible for temporary exception in Medallion II enrollment upon DMAS authorized participation in the following programs:
(a) Treatment Foster Care Case Management
(b) Residential Treatment Services

d. Clients who do not make a selection shall be assigned as follows:

(1) Newly eligible clients shall be assigned to the contracted MCO.

(2) Clients with prior Medallion II participation where there is only one MCO shall be preassigned to the program (MCO or PCCM) where he or she has the most recent history.

(3) Pursuant to 1932 (a)(4), the enrollee can choose to change from the program to which they were preassigned during the first 90 days of enrollment.

5. Open Enrollment

Clients will be notified of their ability to change between the MCO and the Department's PCCM provider at the end of their enrollment period at least sixty (60) days before the end of that period. Enrollment selections will be effective no later than the first day of the second month following the month in which the enrollee makes the request for the change in plans. If the MCO has contractual enrollment limits, the MCO shall be able to retain existing enrollees who select them and shall be able to participate in open enrollment until contractual limits are met.

6. Enrollment Period

Following their initial enrollment into the MCO, Medallion II enrollees shall be restricted to that MCO until the next open enrollment period, unless disenrolled under one of the conditions described in Article II and pursuant with Section 1932 (a)(4)(A) of Title XIX.

For the initial ninety (90) calendar days following the effective date of enrollment, the enrollee will be permitted to disenroll from the MCO to the Department's PCCM provider without cause. This ninety- (90) day time frame during which a client may disenroll without cause applies to the client's initial period of enrollment.

If the enrollee does not disenroll during the ninety- (90) day period, he/she may not disenroll without good cause for the remainder of the enrollment period.

In addition, within sixty (60) days prior to the end of the enrollment period, the Department will inform the enrollee of the opportunity to remain with the current MCO or change to the Department's PCCM provider without cause. Those enrollees who do not make a change within sixty (60) days shall remain in his or her current selection.

The enrollee may disenroll from the MCO to the Department's PCCM provider at any time, for good cause, as defined by the Department.

7. Enrollee Handbook

The Enrollee Handbook must be provided to each enrollee (and potential enrollee if requested) after the Contractor receives notice of the enrollee's enrollment and prior to the first day of the month in which their enrollment starts. Once a year the Department will notify managed care enrollees of their right to request and obtain this information from the Contractor. The Handbook must include at a minimum the following information:

c. Choosing or changing to the Department's PCCM provider (Information shall be listed in the handbook or provided as an insert to the handbook.)

i. Procedures to be followed if the enrollee wishes to change to the Department's PCCM provider.

ARTICLE III - FUNCTIONS AND DUTIES OF THE DEPARTMENT

The Department shall be responsible for the administration of this Contract. Administration of the Contract shall be conducted in good faith within the resources of the State, but in the best interest of the enrollees. The Department shall retain full authority for the administration of the Medicaid/FAMIS Plus Program in accordance with the requirements of Federal and State laws and regulations.

A. DETERMINATION OF MEDICAID/FAMIS PLUS ELIGIBILITY AND MEDALLION II ENROLLMENT

The Department shall have sole responsibility for determining the eligibility of an individual for Medicaid/FAMIS Plus funded services. The Department shall have sole responsibility for determining enrollment in the Contractor's plan.

B. PRE-ASSIGNMENT

In accordance with 12 VAC 30-120-370 (E), the Department will assign recipients to MCOs using a pre-assignment system.

C. ENROLLMENT REPORTS/INFORMATION EXCHANGE

For each month of coverage throughout the term of the Contract, the Department shall post MCO Enrollment Reports to a bulletin board using an electronic data interchange (EDI) transaction set to the Contractor. The date of availability of this information to the bulletin board is dependent upon the Department's eligibility cut-off date and monthly enrollment update cycle. The Department shall provide the Contractor with a copy of the MMIS eligibility cut-off schedule at least semi-annually. The MCO Enrollment reports shall provide the Contractor with ongoing information about its enrollees and disenrollees and shall be used as the basis for the monthly capitation payments. The MCO Enrollment Reports will be generated in the following sequence:

a. The Final Enrollment Report will list all of the Contractor's enrollees for the enrollment month who are known on the report generation date. The Final Enrollment Report will be provided to the Contractor on or before the twenty-fifth (25th) day of the month prior to recipient enrollment. Should the enrollment report be delayed in its delivery to the Contractor, the applicable timeframes for identification card issuance and PCP notification shall be extended by one (1) business day for each day the enrollment report is delayed. The Department and the Contractor shall reconcile each enrollment report as expeditiously as is feasible. The report will be available in electronic format and other formats and will contain at a minimum: enrollee name, Medicaid/FAMIS Plus number, aid category, age, sex, and

indication of capitation region or locality. The report will be sorted by enrollment status (new enrollee or continuing enrollee).

b. The Payment Report will list all of the Contractor's enrollees for the enrollment month who are known on the report generation date. The Payment Report will be provided to the Contractor on or before the fifth (5th) day of the month of client enrollment. The report will be available in electronic and other formats and will contain at a minimum: enrollee name, Medicaid/FAMIS Plus number, aid category, age, sex, an indication of capitation region or locality, and amount of monthly capitation payment for the enrollee. The report will be sorted by enrollment status (new enrollee or continuing enrollee).

c. The Final Enrollment Report will be provided to MCOs through the Virginia Medicaid EDI Bulletin Board.

d. The Contractor shall work with the Department to ensure that the enrollment databases of the Department and the Contractor are reconciled. The Department may audit the Contractor's Medicaid/FAMIS Plus enrollment database.

D. MCO REVIEW OF AUDIT FINDINGS

The Department shall provide the results of any audit findings to the Contractor for review. The Department may seek clarification of the results of any audit findings from the Contractor or its duly authorized representative for the purpose of facilitating the Contractor's understanding of how the audit was conducted and/or how the audit findings were derived. Any such request for clarification shall be in writing from the Contractor to the Department.

If the Contractor disagrees with the audit findings, the Contractor may signify its disagreement by submitting a claim in writing to the Department as provided for in Article VIII.

E. CONTRACT ADMINISTRATION

The Department shall designate a Contract Administrator to act as liaison between the Contractor and the Department. The administrator shall be responsible for:

a. Representing the Department on matters pertaining to the Contract.

b. Receiving and responding to inquiries and requests made by the Contractor, under the Contract, in an expeditious manner.

c. Meeting with the Contractor's representatives on a periodic or as-needed basis and resolving issues which arise.

d. Coordinating requests and activities from the Contractor to ensure that Department staff with appropriate expertise in clinical, financial data, and marketing/enrollment matters are involved in Contractor initiatives and quality improvement goals.

e. Making best efforts to resolve any issues identified either by the Contractor or the Department that may arise that are applicable to the Contract.

f. Monitoring compliance with the terms of this Contract.

F. READINESS REVIEW AND ANNUAL MONITORING

The Department or its duly authorized representative may conduct a readiness review which will include a minimum of one site visit for each MCO that contracts with the Department. This review may be conducted prior to enrollment of any recipients in the MCO and prior to the renewal of the Contract and shall commence within thirty (30) calendar days of the execution of this Contract. The purpose of the review is to provide the Department with assurances that the MCO is able and prepared to perform all administrative functions and to provide high-quality services to enrolled recipients.

Specifically, the review will document the status of the MCO with respect to meeting program standards set forth in this Contract, as well as any goals established by the MCO. The readiness review activities will be conducted by a multidisciplinary team appointed by the Department. The scope of the readiness review will include, but not be limited to, review and/or verification of: network provider composition and access; staffing; content of provider agreements; high-risk perinatal plan; EPSDT plan; financial solvency; and information systems performance and interfacing capabilities. The readiness review may assess the Contractor's ability to meet any requirements set forth in this Contract and the documents referenced herein.

Recipients may not be enrolled in an MCO until the Department has determined that the MCO is capable of meeting these standards. A Contractor's failure to pass the readiness review within ninety (90) calendar days of the execution of this Contract may result in contract termination.

The Department will provide the Contractor with a summary of the findings as well as areas requiring remedial action.

G. CONTRACT MONITORING

The Department's Contract Administrator shall be responsible for conducting an ongoing contract monitoring process. As part of this monitoring process, the Department shall review the performance of the Contractor in relation to the performance standards outlined in this Contract, in the proposal submitted in response to the RFP, and in the RFP. The Department may, at its sole discretion, conduct any or all of the following activities as part of the contract monitoring process:

a. Collect and review standard hard copy and electronic reports and related documentation, including encounter data, which the Contractor is required, under the terms of this Contract, to submit to the Department or otherwise maintain;

b. Conduct MCO, network provider, and subcontractor site visits; and

c. Review MCO policies and procedures and other internal documents.

During the conduct of contract monitoring activities, the Department may assess the Contractor's compliance with any requirements set forth in this contract and in the documents referenced herein.

ARTICLE IV - PAYMENTS TO AND FROM THE MCO

A. PAYMENT TO MCOs

The Department shall issue capitation payments on behalf of enrollees at the rates established in this Contract and modified during the contract renewal process. The Contractor shall accept the annually established capitation rate paid each month by the Department as payment in full for all services to be provided pursuant to this Contract and all administrative costs associated therewith, pending final recoupments, reconciliation, or sanctions. Any and all costs incurred by the Plan in excess of the capitation payment will be borne in full by the Plan.

B. REINSURANCE

The Contractor may obtain reinsurance from an insurer other than the Department for coverage of enrollees under this Contract.

C. RECOUPMENT/RECONCILIATION

The Department shall recoup an enrollee's capitation payment for a given month in cases in which an enrollee's exclusion or disenrollment was effective on or before the fifteenth (15th) day of that month. The Department shall not recoup an enrollee's capitation payment for a given month in cases in which an enrollee's exclusion or disenrollment was effective after the fifteenth (15th) day of that month.

This provision applies to cases where the eligibility or exclusion can occur throughout the month including but not limited to: death of an enrollee, cessation of Medicaid/FAMIS Plus eligibility, inpatient admission to a nursing facility or State mental hospital, approval for HCBS waivered services, hospice services or transfer to a non-managed care eligible Medicaid/FAMIS Plus category. This provision does not apply in cases where the Department is responsible for the total cost of medical care in a given month, e.g., hospitalization at the time of enrollment, ninth month and third trimester pregnancy exclusions, etc. In these cases the total capitation payment for the month will be rescinded.

The Department shall recoup capitation payments made in error by the Department.

When membership is disputed between two Contractors, the Department shall be the final arbitrator of Contractor enrollment and reserves the right to recoup an inappropriate capitation payment.

The Contractor shall not be liable for the payment of any services covered under this Contract rendered to an enrollee after the effective date of the enrollee's exclusion or disenrollment.

If this Contract is terminated, recoupments shall be handled through a payment by the Contractor within thirty (30) calendar days after contract termination or thirty (30) calendar days following determination of specific recoupment requirements, whichever comes last.

The Department shall reconcile payments on a quarterly basis. Included in the quarterly reconciliation shall be additional payments for newborns enrolling with the Contractor, disenrollment/enrollment for hospitalization at the time of enrollment, third trimester pregnancies, ninth month pregnancies, nursing home placement, retroactive adjustments as the result of post payment review, and other adjustments that may be required in accordance with the terms of this contract. This reconciliation shall be made within sixty (60) calendar days of the end of the quarter and shall be based on adjustments known to be needed through the end of the quarter. If reconciliation withholdings exceed reconciliation payments, the Department may, at its option, withhold from subsequent monthly payments or bill the Contractor for the difference, in which case the Contractor shall provide payment within thirty (30) calendar days of the bill date. Payments shall not be made for periods greater than twenty-four (24) months prior to the date of reconciliation.

D. FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) & RURAL HEALTH CLINICS (RHC)

Prior to FQHC or RHC contract signature, the Contractor must notify the Department of the type of financial arrangements negotiated with FQHCs or RHCs. The Contractor must establish the following type of contractual arrangement:

If the FQHC or RHC accepts partial capitation or another method of payment at less than full risk for patient care (i.e., primary care capitation, fee-for-service), the Department will provide a cost settlement to the FQHC or RHC so that the FQHC or RHC is paid the maximum allowable of reasonable costs. In this instance, the Department shall cover the difference between the amount of direct reimbursement paid to the FQHC or RHC by the Contractor and the FQHC's or RHC's reasonable costs for services provided to Contractor patients. This arrangement applies only to patient care costs of Medallion II enrollees.

The Contractor must provide assurances that it is paying the FQHC or RHC at a rate that is comparable to the rate it is paying other providers of similar services, and the Contractor shall provide supporting documentation at the Department's request.

Within ten (10) business days of establishing or changing such an arrangement, the Contractor shall notify the Department in writing about the type of arrangement it has established.

E. BILLING ENROLLEES FOR MEDICALLY NECESSARY SERVICES

The Contractor and its subcontractors are subject to criminal penalties if providers knowingly and willfully charge, for any service provided to a recipient under the State Plan or under this Contract, money or other consideration at a rate in excess of the rate established by the Department, as specified in Section 1128B(d)(1) of the Social Security Act (42 U.S.C. § 1320a-7b), as amended. This provision shall continue to be in effect even if the Contractor becomes insolvent until such time as enrollees are withdrawn from assignment to the Contractor.

Pursuant to Section 1932(b)(6), (42 U.S.C. § 1396u-2 (b)(6)), the Contractor and all of its subcontractors shall not hold a recipient liable for:

a. Debts of the Contractor in the event of the Contractor's insolvency;

b. Payment for services provided by the Contractor if the Contractor has not received payment from the Department for the services or if the provider, under contract or other arrangement with the Contractor, fails to receive payment from the Department or the Contractor; or

c. Payments to providers that furnish covered services under a contract or other arrangement with the Contractor that are in excess of the amount that normally would be paid by the recipient if the service had been received directly from the Contractor.

F. BILLING ENROLLEES FOR OTHER SERVICES

The Contractor, including its network providers and subcontractors, shall not bill an enrollee for any services provided under this Contract. The Contractor shall assure that all in network provider agreements (Reference Attachment V. Section A. number 11.) include requirements whereby the enrollee shall be held harmless for charges for any Medicaid/FAMIS Plus covered service. This includes those circumstances where the provider fails to obtain necessary referrals, preauthorizations, or fails to perform other required administrative functions. However, if an enrollee agrees in advance of receiving the service and in writing to pay for a service that is not a State Plan covered service, then the Contractor, directly or through its network provider or subcontractor can bill the enrollee for the service.

G. THIRD-PARTY LIABILITY (TPL)

1. Comprehensive Health Coverage

Individuals enrolled in Medicaid/FAMIS Plus, determined by the Department as having comprehensive health coverage including Medicare, will be assigned to the fee-for-service program, effective the first day of the month following the month in which the coverage was verified. Members will not be retroactively

disenrolled due to comprehensive health coverage. Until disenrollment occurs, the MCO is responsible for coordinating all benefits and following Medicaid/FAMIS Plus "payor of last resort" rules. This means that deductibles and coinsurance are covered by the contracted MCO up to the maximum reimbursement amount that would have been paid in the absence of other primary insurance coverage.

Under Section 1902 (a)(25) of the Social Security Act (42 U.S.C. §1396 a (a)(25)), the State is required to take all reasonable measures to identify legally liable third parties and pursue verified resources. In cases in which the recipient was not identified for exclusion prior to enrollment in the MCO, the Contractor shall take responsibility for identifying and pursuing comprehensive health coverage. Any moneys recovered by third parties shall be retained by the Contractor and identified monthly to the Department. The Contractor shall notify DMAS on a monthly basis of any enrollees identified during that past month who were discovered to have comprehensive health coverage.

2. Workers' Compensation

If a member is injured at his or her place of employment and files a workers' compensation claim, the Contractor shall remain responsible for all services. The Contractor may seek recoveries from a claim covered by workers' compensation if the Contractor actually reimbursed providers and the claim is approved for the workers' compensation fund. The Contractor shall notify DMAS on a monthly basis of any enrollees identified during that past month who are discovered to have workers' compensation coverage.

If the member's injury is determined not to qualify as a worker's compensation claim, the Contractor shall be responsible for all services provided while the injury was under review, even if the services were provided by out-of-network providers, in accordance with worker's compensation regulations.

3. Estate Recoveries

The Contractor is prohibited from collecting estate recoveries. The Contractor shall notify DMAS on a monthly basis of any enrollees identified during that past month who have died and are over the age of 55.

4. Other Coverage

The Department retains the responsibility to pursue, collect, and retain all non-health insurance resources such as casualty, liability, estates, child support, and personal injury claims. The Contractor is not permitted to seek recovery of any non-health insurance funds.

Individuals with these other resources shall remain enrolled in the MCO. The Contractor shall notify DMAS on a monthly basis of any enrollees identified

during that past month who are discovered to have any of the above coverages, including enrollees identified as having trauma injuries. (Reference Attachment XII for the suggested format to use when reporting potential coverage secondary to an accident.) The Contractor shall provide DMAS with all encounter/claims data associated with care given to recipients who have been identified as having any of the above coverages.

ARTICLE V - REMEDIES FOR VIOLATION, BREACH, OR NON-PERFORMANCE OF CONTRACT

Upon receipt by the Department of evidence of substantial non-compliance by the Contractor with any of the provisions of this Contract or with State or federal laws or regulations including, but not limited to, the requirements of or pursuant to Section F of 12 VAC 30-120-380, as amended, the following remedies may be imposed:

A. PROCEDURE FOR CONTRACTOR NONCOMPLIANCE NOTIFICATION

In the event that the Department identifies or learns of noncompliance with the terms of this contract, the Department will notify the Contractor in writing of the nature of the noncompliance. The Contractor must remedy the noncompliance within a time period established by the Department, and the Department will designate a period of time, not less than ten (10) calendar days, in which the Contractor must provide a written response to the notification. The Department may develop or may require the Contractor to develop procedures with which the Contractor must comply to eliminate or prevent the imposition of specific remedies.

These administrative procedures shall not supersede the administrative procedures set forth in Section C of this Article and those required by the Federal government.

B. SPECIFIC COMPLIANCE EMPHASIS

While the Department requires strict compliance with all contract provisions, it places particular emphasis on prompt, accurate, and complete compliance with requirements related to the following:

- access to medical services;
- marketing activities;
- issuance of enrollee ID cards;
- submission of encounter data;
- submission of requested medical records; and
- submission of required reports.

Contractors may expect the prompt imposition of stringent remedies for failure to comply with contractual requirements associated with failure to comply with contractual requirements associated with these priority items.

C. REMEDIES AVAILABLE TO THE DEPARTMENT

The Department reserves the right to employ, at the Department's sole discretion, any of the remedies and sanctions set forth below and to resort to other remedies provided by law. In no event may the application of any of the following

remedies preclude the Department's right to any other remedy available in law or regulation.

1. Remedies

In the event of any breach of the terms of the Contract by the Contractor, the Contractor shall pay damages to the Department for such breach at the sole discretion of the Department, at a minimum, according to the following subsections.

If, in a particular instance, the Department elects not to exercise a damage clause or other remedy contained herein, this decision shall not be construed as a waiver of the Department's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the RFP or Contract, may be retroactively assessed.

a. Federally-Prescribed Sanctions For Noncompliance

i. Section 1932(e)(1)(A) of the Social Security Act (the Act) describes the use of intermediate sanctions for States. Such sanctions may include any of the ones described in subparagraph C.1.a.ii through C.1.a.vii below, and may be imposed if the managed care organization:

(a) fails to substantially provide medically necessary items and services that are required (under law or under such organization's contract with the State) to be provided to an enrollee covered under the contract;

(b) imposes premiums or charges enrollees in excess of the premiums or charges permitted under Title XIX of the Act;

(c) acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to re-enroll an individual, except as permitted by Title XIX of the Act, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the entity by eligible individuals whose medical condition or history indicates a need for substantial future medical services;

(d) fails to comply with the physician incentive requirements under section 1903(m)(2)(A)(x) of the Act.

In addition, the State may impose sanctions against a managed care entity if the State determines that the entity distributed directly, or through any agent or independent

contractor marketing materials that contain false or misleading information.

ii. Section 1932(e)(2)(A) of the Act allows the State to impose the following civil money penalties:

(a) for each determination that the managed care organization (MCO) fails to substantially provide medically necessary services or fails to comply with the physician incentive plan requirements, a maximum of $25,000.

(b) for each determination that the MCO discriminates among enrollees on the basis of their health status or requirements for health care services or engages in any practice that has the effect of denying or discouraging enrollment with the entity by eligible individuals based on their medical condition or history that indicates a need for substantial future medical services, or the MCO misrepresents or falsifies information furnished to the Secretary of Health and Human Services, State, enrollee, potential enrollee, or health care provider, a maximum of $100,000.

(c) for each determination that the MCO has discriminated among enrollees or engaged in any practice that has denied or discouraged enrollment, the money penalty may be as high as $15,000 for each individual not enrolled as a result of the practice, up to a maximum of $100,000.

(d) with respect to a determination that the MCO has imposed premiums or charges on enrollees in excess of the premiums or charges permitted, the money penalty may be a maximum of $25,000 or double the amount of the excess charges, whichever is greater. The excess amount charged must be deducted from the penalty and returned to the enrollee concerned.

iii. Section 1932(e)(2)(B) of the Act specifies the conditions for appointment of temporary management:

(a) Temporary management is imposed if the State finds that there is continued egregious behavior by the MCO or there is substantial risk to the health of the enrollees. Temporary management may also be imposed if there is a need to assure the health of the organization's

enrollees during an orderly termination or reorganization of the MCO or while improvements are made to correct violations.

(b) Once temporary management is appointed, it may not be removed until it is determined that the organization has the capability to ensure that the violations will not recur.

iv. Sections 1932(e)(2)(C), (D), and (E) of the Act describe other sanctions that may be imposed:

(a) The State may permit individuals enrolled in a managed care entity to disenroll without cause.

(b) The State may suspend or default all enrollment of Medicaid/FAMIS Plus beneficiaries after the date the Secretary of Health and Human Services or the State notifies the entity of a violation determination under Section 1903(m) or Section 1932(e) of the Act.

(c) The State may suspend payment to the entity under Title XIX for individual enrollees after the date the Secretary of Health and Human Services or the State notifies the entity of the determination and until the entity has satisfied the Secretary or the State that the basis for such determination has been corrected and will not likely recur.

v. Section 1932(e)(3) of the Act specifies that if an MCO has repeatedly failed to meet the requirements of Section 1903(m) or Section 1932(e) of the Act, the State must (regardless of what other sanctions are provided) impose temporary management and allow individuals to disenroll without cause.

vi. Section 1932(e)(4) of the Act allows the State to terminate contracts of any managed care entity that has failed to meet the requirements of Section 1903(m), 1905(t)(3), or 1932(e) of the Act and enroll the entity's enrollees with other managed care entities or allow enrollees to receive medical assistance under the State Plan other than through a managed care entity.

vii. Title 42 CFR § 438.730 allows the State to recommend that CMS impose the denial of payment sanction for new enrollees of the managed care organization when, and for so long as, payment for those enrollees is denied by CMS in accordance with the

requirements set forth in 42 CFR 438.730, as described in Article V section C of this Contract.

viii. The State must give the managed care entity a hearing before termination occurs, and the State must notify the individuals enrolled with the managed care entity of the hearing and allow the enrollees to disenroll if they choose without cause.

b. Other Specified Remedies

If the Department determines that the Contractor failed to provide one (1) or more of the contract services required under the contract, or that the Contractor failed to maintain or make available any records or reports required under the Contract by the Department which the Department may use to determine whether the Contractor is providing contract services as required, the following remedies may be imposed:

i. Suspensions of New Enrollment

The Department may suspend the Contractor's right to enroll new Medicaid/FAMIS Plus participants (voluntary, automatically assigned, or both) under this Contract. The Department may make this remedy applicable to specific populations served by the Contractor or the entire contracted area. The Department, when exercising this option, must notify the Contractor in writing of its intent to suspend new Medicaid/FAMIS Plus enrollment at least thirty (30) calendar days prior to the beginning of the suspension period. The suspension period may be for any length of time specified by the Department, or it may be indefinite. The Department may also suspend new Medicaid/FAMIS Plus enrollment or disenroll Medicaid/FAMIS Plus recipients in anticipation of the Contractor not being able to comply with any requirement of this Contract or with federal or State laws or regulations at its current enrollment level. Such suspension shall not be subject to the thirty (30) calendar day notification requirement.

The Department may also notify enrollees of Contractor non-compliance and provide such enrollees an opportunity to enroll with another MCO.

ii. Department-Initiated Disenrollment

The Department may reduce the number of current enrollees by disenrolling the Contractor's

Medicaid/FAMIS Plus enrollees. The Contractor shall be given at least thirty (30) calendar days notice prior to the Department taking any action set forth in this paragraph.

iii. Reduction in Maximum Enrollment Cap

The Department may reduce the maximum enrollment level or number of current Medicaid/FAMIS Plus enrollees. The Contractor shall be given at least thirty (30) calendar days notice prior to the Department taking any action set forth in this paragraph.

iv. Suspension of Marketing Services and Activities

The Department may suspend a Contractor's marketing activities which are geared toward potential enrollees. The Contractor shall be given at least ten (10) calendar days notice prior to the Department taking any action set forth in this paragraph.

c. Withholding of Capitation Payments and Recovery of Damage Costs

When the Department withholds payments under this section, the Department must submit to the Contractor a list of the members for whom payments are being withheld, the nature of the services denied, and payments the Department must make to provide medically necessary services. In any case under this Contract where the Department has the authority to withhold capitation payments, the Department also has the authority to use all other legal processes for the recovery of damages. The Department may withhold portions of capitation payments or otherwise recover damages from the Contractor in the following situations:

i. Whenever the Department determines the Contractor failed to provide one (1) or more of the medically necessary Medallion II covered contract services, the Department may direct the Contractor to provide such service or withhold a portion of the Contractor's capitation payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services. The Contractor shall be given at least seven (7) calendar days written notice prior to the withholding of any capitation payment.

ii. Whenever the Department determines that the Contractor has failed to perform an administrative function required

under the Contract, the Department may withhold a portion of future capitation payments to compensate for the damages which this failure entails. For the purposes of this section, "administrative function" is defined as any contract service.

iii. In any case where the Department intends to withhold capitation payments or recover damages through the exercise of other legal processes, the following procedures shall be used:

(a) The Department shall notify the Contractor of the Contractor's failure to perform required administrative functions under the Contract.

(b) The Department shall give the Contractor thirty (30) calendar days notice to develop an acceptable plan for correcting this failure.

(c) If the Contractor has not submitted an acceptable correction action plan within thirty (30) calendar days, or has not implemented this plan within the timeframe in the approved action plan, the Department will provide the Contractor with a written document itemizing the damage costs for which it intends to require compensation seven (7) calendar days prior to withholding any capitation payment. The Department shall then proceed to recover said compensation.

d. Probation

The Department may place a Contractor on probation, in whole or in part, if the Department determines that it is in the best interest of Medicaid/FAMIS Plus recipients and the Department. The Department may do so by providing the Contractor with a written notice explaining the terms and the time period of the probation. The Contractor shall, immediately upon receipt of such notice, provide services in accordance with the terms set forth and shall continue to do so for the period specified or until further notice. When on probation, the Contractor shall work in cooperation with the Department, and the Department may institute ongoing review and approval of Contractor Medicaid/FAMIS Plus activities.

e. Suspension of Contractor Operations

The Department may suspend a Contractor's Medallion II operations, in whole or in part, if the Department determines that it is in the best interest

of Medallion II recipients to do so. The Department may do so by providing the Contractor with written notice. The Contractor shall, immediately upon receipt of such notice, cease providing services for the period specified in such notice, or until further notice.

f. Remedial Actions

The Department may pursue all remedial actions with the Contractor that are taken with Medicaid fee-for-service providers. The Department will work with the Contractor, and the Contractor's network providers to change and correct problems and will recoup funds if the Contractor fails to correct a problem within a timely manner.

g. Remedies not Exclusive

The remedies available to the Department as set forth above are in addition to all other remedies available to the Department in law or in equity, are joint and severable, and may be exercised concurrently or consecutively. Exercise of any remedy in whole or in part shall not limit the Department in exercising all or part of any other remedies.

D. APPEAL RIGHTS OF THE CONTRACTOR

For violations set forth in both 42 C.F.R. 434.67 (a) and 12 VAC 30-120-400, the Department may impose the sanctions provided therein.

The Department shall follow the procedures set forth in 12 VAC 30-120-410- and C.F.R. 42 434.67 (a) allowing them to impose the sanctions provided therein.

The Contractor shall have all the appeal rights provided for in 42 C.F.R. 434.67 (a) and 12 VAC 30-120-410.

For all other sanctions the Contractor shall have the appeal rights provided for in the Virginia Public Procurement Act, 11-35 et. seq. of the Code of Virginia.

E. ATTORNEY FEES

In the event the Department shall prevail in any legal action arising out of the performance or non-performance of this Contract, the Contractor shall pay, in addition to any damages, all expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

ARTICLE VI - CONTRACT TERM AND RENEWAL

The effective date of this Contract is July 1, 2004. This Contract will be effective until June 30, 2005.

The service areas and capitation rates for this Contract are referenced in Attachment XXV.

The Contract shall automatically renew for six additional months if, on the ending date of this Contract, the Contractor and the Department are actively involved in good faith renegotiations of this Contract or negotiation of another risk based Contract. The capitation rates for this automatic renewal period will be set at the discretion of the Department.

The Contractor may opt out of the above automatic renewal clause. In order to do so, the Contractor must notify the Department in writing at least six (6) full calendar months prior to the renewal. If the Contractor fails to notify the Department of non-renewal on or before this date, the Contract will be automatically renewed.

ARTICLE VII - TERMINATION

A. TERMINATION

This Contract may be terminated in whole or in part:

a. By the Department or the Contractor, for convenience, with sufficient written notice,

b. By the Department, in whole or in part, if funding from Federal, State, or other sources is withdrawn, reduced, or limited;

c. By the Department if the Department determines that the instability of the Contractor's financial condition threatens delivery of Medallion II services and continued performance of the Contractor's responsibilities; or

d. By the Department if the Department determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities.

Each of these conditions for contract termination is described in the following paragraphs.

1. Termination for Convenience

The Contractor may terminate this Contract with or without cause, upon six (6) full calendar months written notice to the Department. In addition, the Contractor may terminate the Contract, as provided in Article VI of this Contract, by opting out of the renewal clause.

2. Termination for Unavailable Funds

The Contractor understands and agrees that the Department shall be bound only to the extent of the funds available or which may become available for the purpose of this resulting Contract. When the Department makes a written determination that funds are not adequately appropriated or otherwise unavailable to support continuance of performance of this Contract, the Department shall, in whole or in part, cancel or terminate this Contract.

The Department's payment of funds for purposes of this Contract is subject to and conditioned upon the availability of funds for such purposes, whether Federal and/or State funds. The Department may terminate this Contract upon written notice to the Contractor at any time prior to the completion of this Contract if, in the sole opinion of the Department, funding becomes unavailable for these

services or such funds are restricted or reduced. In the event that funds are restricted or reduced, it is agreed by both parties that, at the sole discretion of the Department, this Contract may be amended. Shall the Contractor be unable or unwilling to provide covered services at reduced capitation rates, the Contract shall be terminated.

No damages, losses, or expenses may be sought by the Contractor against the Department if, in the sole determination of the Department, funds become unavailable before or after this Contract between the parties is executed. A determination by the Department that funds are not appropriated or are otherwise inadequate or unavailable to support the continuance of this Contract shall be final and conclusive.

3. Termination Because of Financial Instability

In the event the Contractor becomes financially unstable to the point of threatening the ability of the Department to obtain the services provided for under the Contract, ceases to conduct business in normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or assets, the Department may, at its option, immediately terminate this Contract effective at the close of business on a date specified by the Department. In the event the Department elects to terminate the Contract under this provision, the Contractor shall be notified in writing by either certified or registered mail, specifying the date of termination. The Contractor shall submit a written waiver of the licensee's rights under the Federal bankruptcy laws.

In the event of the filing of a petition in bankruptcy by a principal network provider or subcontractor, the Contractor shall immediately so advise the Department. The Contractor shall ensure that all tasks that have been delegated to its subcontractor(s) are performed in accordance with the terms of this Contract.

4. Termination for Default

The Department may terminate the Contract, in whole or in part, if the Department determines that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract and is unable to cure such failure within a reasonable period of time as specified in writing by the Department, taking into consideration the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

Upon determination by the Department that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract, the Contractor shall be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable to cure the failure within the specified time period, the Department will notify the Contractor in writing within thirty (30) calendar days of the last day of the specified time period that the Contract has been terminated,

in full or in part, for default. This written notice will identify all of the Contractor's responsibilities in the case of the termination, including responsibilities related to enrollee notification, network provider notification, refunds of advance payments, and liability for medical claims.

If, after notice of termination for default, it is determined by the Department or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of and without error or negligence on the part of the Contractor or any of its subcontractors, the notice of termination shall be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties shall be governed accordingly.

In the event of termination for default, in full or in part, as provided for under this clause, the Department may procure from other sources, upon such terms and in such manner as is deemed appropriate by the Department, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the Department for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. In the event of a termination for default prior to the start of operations, any claim the Contractor may assert shall be governed by the procedures defined by the Department for handling contract termination. Nothing herein shall be construed as limiting any other remedies which may be available to the Department.

In the event of a termination for default during ongoing operations, the Contractor shall be paid for any outstanding capitation payments due less any assessed damages.

B. TERMINATION PROCEDURES

1. Liability for Medical Claims

The Contractor shall be liable for all medical claims incurred up to the date of termination. This shall include all of the hospital inpatient claims incurred for enrollees hospitalized at the time of termination.

2. Refunds of Advanced Payments

If the Contract is terminated under this article, the Contractor shall be entitled to be paid a pro-rated capitation amount for the month in which notice of termination was effective to cover the services rendered to enrollees prior to the termination. The Contractor shall not be entitled to be paid for any services performed after the effective date of the termination. The Contractor shall, within thirty (30) calendar days of receipt, return any funds advanced for coverage of members for periods after the date of termination of the Contract.

3. Notification of Enrollees

In all cases of termination, the Contractor shall be responsible for notifying enrollees about the termination, and the Department shall be responsible for reassigning enrollees to new MCOs, as appropriate. In cases of termination for default or financial instability, the Contractor shall be responsible for covering the costs associated with such notification. In cases of termination for convenience, the costs associated with such notification shall be the responsibility of the party which terminated the Contract. In cases of termination due to unavailability of funds or termination in the best interest of the Department, the Department shall be responsible for the costs associated with such notification. The Contractor shall conduct these notification activities within a time frame established by the Department.

4. Notification of Network Providers

In all cases of termination, the Contractor shall be responsible for notifying its network providers about the termination of the Medallion II Contract and about the reassigning of its enrollees to other MCOs and for covering the costs associated with such notification. The Contractor shall conduct these notification activities within a time frame established by the Department.

5. Other Procedures on Termination

Upon delivery by certified or registered mail to the Contractor of a Notice of Termination specifying the nature of the termination and the date upon which such termination becomes effective, the Contractor shall:

a. Stop work under the Contract on the date specified and to the extent specified in the Notice of Termination;

b. Place no further orders or subcontracts for materials, services, or facilities;

c. Terminate all orders, provider network agreements and subcontracts to the extent that they relate to the performance of work terminated by the Notice of Termination;

d. Assign to the Department in the manner and to the extent directed all of the rights, titles, and interests of the Contractor under the orders or subcontracts so terminated, in which case the Department shall have the right, at its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts;

e. Within ten (10) business days from the effective date of termination, transfer title to the State (to the extent that the title has not already been transferred) and deliver, in the manner and to the extent directed, all data, other information, and documentation in any form that relates to the work terminated by the Notice of Termination;

f. Complete the performance of such part of the work as has not been specified for termination by the Notice of Termination;

g. Take such action as may be necessary, or as the Department may direct, for the protection and preservation of the property which is in the possession of the Contractor and in which the Department has acquired or may acquire interest; and

h. Assist the Department in taking the steps necessary to assure an orderly transition of requested services after notice of termination.

The Contractor hereby acknowledges that any failure or unreasonable delay on its part in affecting a smooth transition will cause irreparable injury to the State which may not be adequately compensable in damages. The Contractor agrees that the Department may, in such event, seek and obtain injunctive relief as well as monetary damages. Any payments made by the Department pursuant to this section may also constitute an element of damages in any action in which Contractor fault is alleged.

The Contractor shall proceed immediately with the performance of the above obligations, notwithstanding any delay in determining or adjusting the amount of any item of reimbursable price under this clause.

Upon termination of this Contract in full, the Department shall require the Contractor to return to the Department any property made available for its use during the Contract term.

ARTICLE VIII - DISPUTES

A. RIGHT TO APPEALS

The Contractor shall have the right to appeal any adverse action taken by the Department. All appeals arising out of a sanction or remedy levied pursuant to Article V of this Contract shall be handled in accordance with Article V.

For appeals not addressed by Article V, the Contractor shall proceed in accordance with the appeals provisions in the Code of Virginia, § 11-35, as amended, et seq. (the Virginia Public Procurement Act). Pursuant to the Code of Virginia §§ 11-70 and 11-71, as amended, the Department establishes an administrative appeals procedure under which the Contractor may elect to appeal decisions on disputes arising during the performance of its Contract. In conducting the administrative appeal, the hearing officer shall follow the hearing procedure like that in Code of Virginia § 9-6.14:12, as amended.

The Contractor may not submit to the Department for resolution under this section disputes relating to Medicaid/FAMIS Plus eligibility requirements or Medallion II covered services.

B. DISPUTES ARISING OUT OF THE CONTRACT

As provided for in Code of Virginia § 11-69, as amended, disputes arising out of the Contract, whether for money or other relief, are to be submitted by the Contractor for consideration by the Department. Disputes must be submitted in writing, with all necessary data and information, to the Contract Administrator or designee.

Disputes will not be considered if submitted later than sixty (60) calendar days after the date on which the Contractor knew of the occurrence giving rise to the dispute or the beginning date of the work upon which the dispute is based, whichever is earlier. Further, no claim may be submitted unless written notice of the Contractor's intention to file the dispute has been submitted at least thirty (30) calendar days prior to a formal filing of the dispute, and such thirty (30) calendar days is to be counted from the date of the occurrence or the beginning date of the work upon which the dispute is based, whichever is earlier.

C. INFORMAL RESOLUTION OF DISPUTES ARISING OUT OF THE CONTRACT

For any dispute arising out of the Contract, except for any dispute resulting from any breach of statute or regulation, the parties shall first attempt to resolve their differences informally. Should the parties fail to resolve their differences after good-faith efforts to do so, then the parties may proceed with formal avenues for resolution of the dispute.

D. PRESENTATION OF DOCUMENTED EVIDENCE

The Contractor is obligated to present to the Department all witnesses, documents, or other evidence necessary to support its claim. Evidence that the Contractor has but fails to present to the Department will be deemed waived and may not be presented to the Circuit Court.

The Contractor shall have the burden of proving to the Department by a preponderance of the evidence that the relief it seeks should be granted.

ARTICLE IX - SECURITY AND CONFIDENTIALITY OF RECORDS

A. USE OR DISCLOSURE OF INFORMATION

The use or disclosure of information concerning Contract services or enrollees obtained in connection with the performance of this Contract shall be in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule requirements and the State Plan and is restricted to purposes directly related to the administration and the provision of services provided under this Contract.

1. Disclosure and Confidentiality

The Contractor must have a confidentiality agreement in place with individuals of its workforce who have access to PHI. A sample Authorized Workforce Confidentiality Agreement is included as Attachment I of this contract. Issuing and maintaining these confidentiality agreements will be the responsibility of the Contractor. The Department shall have the option to inspect the maintenance of said confidentiality agreements.

2. Disclosure to Workforce

The Contractor shall not disclose PHI to any member of its workforce except to those persons who have authorized access to the information, who have received privacy training in PHI, and who have signed an agreement to hold the information in confidence.

The Contractor understands and agrees that data, materials, and information disclosed to the Contractor may contain confidential and protected data. The Contractor, therefore, must ensure that data, material, and information gathered, based upon or disclosed to the Contractor for the purpose of this Contract, shall not be disclosed to others or discussed with other outside parties without the prior written consent of the Commonwealth of Virginia.

3. Safeguards

The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of protected health information (PHI), other than as provided in this Contract. A description of such safeguards must be in the form of a contractor Data Security Plan (DSP). A sample DSP is included as Attachment XI to this contract. Upon reasonable request, the Contractor shall give the Department access for inspection and copying to the Contractor's facilities used for the maintenance or processing of PHI, and to books, records, practices, policies and procedures concerning the

use and disclosure of PHI, including DSPs, for the purpose of determining the Contractor's compliance with this agreement.

4. Accounting of Disclosures

The Contractor shall maintain an ongoing log of the details relating to any disclosures of PHI it makes (including, but not limited to, the date made, the name of the person or organization receiving the PHI, the recipient's address, if known, a description of the PHI disclosed, and the reason for the disclosure), as required by 45 CFR, Section 164.528. The Contractor shall, within thirty (30) days of the Department's request, make such log available to the Department as needed, for the Department to provide a proper accounting of disclosures to its patients.

5. Disclosure to the U.S. Department of Health and Human Services

The Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from the Department (or created or received by the Contractor on behalf of the Department) available to the Secretary of the Department of Health and Human Services (DHHS) or its designee for purposes of determining the Contractor's compliance with HIPAA and with the Privacy Regulations issued pursuant thereto. The Department shall provide the Contractor with copies of any information it has made available to DHHS under this section of this contract.

6. Reporting

The Contractor shall report to the Department within thirty (30) days of discovery, any use or disclosure of PHI made in violation of this Contract or any law. The Contractor shall implement and maintain sanctions for any employee, subcontractor, or agent who violates the requirements in this Contract or the HIPAA privacy regulations. The Contractor shall, as requested by the Department, take steps to mitigate any harmful effect of any such violation of this Contract.

7. Access to PHI

The Contractor shall make an individual's PHI available to the Department within thirty (30) days of an individual's request for such information as notified and in the format requested by the Department.

8. Amendment to PHI

The Contractor shall make PHI available for amendment and correction and shall incorporate any amendments or corrections to PHI within thirty (30) days of notification by the Department.

The Contractor hereby agrees to comply with the terms set forth in the Department's Confidentiality Agreement, Attachment X.

B. ACCESS TO CONFIDENTIAL INFORMATION

Except as otherwise required by law, including, but not limited to, the Virginia Freedom of Information Act, access to confidential information shall be limited by the Contractor and the Department to persons who or agencies which require the information in order to perform their duties related to this Contract, including the United States Department of Health and Human Services; the Office of the Attorney General of the Commonwealth of Virginia, including the Medicaid Fraud Control Unit; and such others as may be required by the Department.

In complying with the requirements of this section, the Contractor and the Commonwealth shall follow the requirements of 42 CFR Part 431, Subpart F, as amended, regarding confidentiality of information concerning applicants and recipients of public assistance, and 42 CFR Part 2, as amended, regarding confidentiality of alcohol and drug abuse patient records.

The Contractor must have written policies and procedures for maintaining the confidentiality of data, including medical records and enrollee information and appointment records for treatment of sexually transmitted diseases and submit annually to the Department.

The Contractor shall comply with the Department's Security Requirements for Vendors.

C. DATA SECURITY PLAN

By executing this Contract, the Contractor agrees to work with the Department's Division of Internal Audit to create a Data Security Plan governing the Contractor's use of Department data. Attachment XI summarizes the basic requirements for such a Data Security Plan, the final contents of which will be negotiated between the Contractor and the Division of Internal Audit.

D. AUDITS, INSPECTIONS AND ENFORCEMENT

With reasonable notice, the Department may inspect the facilities, systems, books and records of the Contractor to monitor compliance with HIPAA. The Contractor shall promptly remedy any violation of any term of HIPAA and shall certify the same to the Department in writing. The fact the Department inspects,

or fails to inspect, or has the right to inspect, the Contractor's facilities, systems and procedures does not relieve the Contractor of its responsibility to comply with HIPAA, nor does the Department's failure to detect, or to detect but fail to call the Contractor's attention to or require remediation of any unsatisfactory practice constitute acceptance of such practice or waiving of the Department's enforcement rights.

The Department may terminate the Agreement without penalty if the Contractor repeatedly violates HIPAA or any provision hereof, irrespective of whether, or how promptly, the Contractor may remedy such violation after being notified of the same. In case of any such termination, the Department shall not be liable for the payment of any services performed by the Contractor after the effective date of the termination, and the Department shall be liable to the Contractor in accordance with the Agreement for services provided prior to the effective date of termination.

The Contractor acknowledges and agrees that any individual who is the subject of PHI disclosed by the Department to the Contractor is a third party beneficiary of HIPAA and may, to the extent otherwise permitted by law, enforce directly against the Contractor any rights such individual may have under this HIPAA, the Agreement, or any other law relating to or arising out of the Contractor's violation of any provision of HIPAA.

ARTICLE X - DOCUMENTS CONSTITUTING THE CONTRACT

A. DOCUMENTS THAT CONSTITUTE THE CONTRACT

The documents that constitute this Contract are the following:

a. This document;

b. Subsequent modifications approved in writing by the Contractor and the Department.

In addition, the Contract hereby incorporates the following attachments:

i. Authorized Workforce Confidentiality Agreement
ii. Summary of Medicaid/FAMIS Plus Covered, Medallion II Covered Services
iii. MCO Active Provider File Data Requirements
iv. DMAS Form 213-MCO For Newborns
v. Network Provider Agreement
vi. Inquiry, Grievance and Appeals Monthly Summary Report
vii. Reporting Requirements
viii. Disproportionate Share Hospital Report
ix. Live Birth Outcomes Report
x. Confidentiality Agreement
xi. Format for Data Security Plan
xii. Third Party Accident Reports
xiii. Grievance and Appeals Reasons
xiv. Sentinel Event Report
xv. High Risk Maternity and Infant Program Report
xvi. Managed Care Monthly Report
xvii Facility Payment Layout
xviii Open Enrollment Effective Dates by Region
xix Monthly EDI Report to Enrollment Broker
xx Annual Notice of Health Care Rights
xxi Health Status Survey Questionnaire
xxii Certification of Encounter Data
xxiii. Certification of Data
xxiv. MCO Specific Contract Terms/Signature Page
xxv.i through xxv.ii MCO Specific Contract Terms Continued

B. ORDER OF PRECEDENCE

The documents listed above shall constitute the entire Contract between the parties, and no other expression, whether oral or written, shall constitute any part of this Contract. Any conflict, inconsistency, or ambiguity among the contract documents shall be resolved by giving legal order of precedence in the following order:

a. Federal Regulations
b. Virginia State Plan

c. Medallion II Waiver
d. Medallion II State Regulations
e. Medallion II Contract, including all amendments and attachments including Medicaid memos and manuals

Any ambiguity in the interpretation of this Contract shall be resolved in accordance with the requirements of Federal and Virginia laws and regulations, including the State Plan for Medical Assistance Services and Department memos, notices, and provider manuals.

Services listed as covered in any evidence of coverage or any enrollee handbook shall not take precedence over the services required under this Contract or the State Plan for Medical Assistance.

ARTICLE XI - MISCELLANEOUS

A. AGREEMENT TO TERMS AND CONDITIONS

Through submittal of the response of the Department's request for Proposals and by signing this Contract, the Contractor shall accept and agree to all of the terms, conditions, criteria, and requirements set forth in these documents and their attachments. Acceptance of the terms and conditions shall serve as a waiver of any and all objections by the Contractor as to the contents of the Department's RFP and this Contract.

B. MISREPRESENTATION OF INFORMATION

Misrepresentation of a Contractor's status, experience, or capability in the performance of this Contract may result in termination. Existence of known litigation or investigations in similar areas of endeavor may, at the discretion of the Department, result in immediate Contract termination and/or replacement.

C. MEETINGS

The Contractor shall participate in meetings with the Department of Medical Assistance Services, including the Case Manager's meetings, DMAS Managed Care Advisory Committee meetings, MCO Work-Group meetings, etc., Quality Assurance Committees, or any other groups as necessary when requested to do so by the Department.

D. GOVERNING LAW

The Contract shall be governed and construed in accordance with the laws and regulations of the Commonwealth of Virginia.

E. INDEMNIFICATION

The Contractor hereby agrees to defend, hold harmless and indemnify the Department, its officers, agents and employees from any and all claims by third parties, regardless of their nature or validity, arising out of the performance of this Contract by the Contractor or its agents, employees, or subcontractors including, but not limited to, any liability for costs and expenses, for violation of proprietary rights, copyrights, or rights of privacy arising out of the publication, translation, reproduction, delivery, performance, use or disposition of any data furnished under this Contract or based on any libelous or other unlawful matter contained in such data.

The Contractor is not required to defend, hold harmless or indemnify the Department, its officers, agents, and employees from claims resulting from services provided by an Agency of the Commonwealth of Virginia or its officers,

agents, and employees when and if the Agency is expressly serving as a subcontractor under the provisions of this Contract.

F. INDEPENDENT CAPACITY

The Contractor and the agents and employees of the Contractor, in the performance of this Contract, shall act as independent Contractors and shall not act or represent themselves as officers, employees or agents of the Department or of the Commonwealth.

G. CONTRACTOR LIABILITY

The Contractor assumes full financial liability for developing and managing a health care delivery system that will arrange for or administer all covered services outlined in this Contract.

H. DRUG-FREE WORKPLACE

The Contractor shall acknowledge and certify that it understands that the following acts by the Contractor, its employees, and/or agents performing services on State property are prohibited from:

a. The unlawful manufacture, distribution, dispensing, possession or use of alcohol or other drugs; and

b. Any impairment or incapacitation from the use of alcohol or other drugs (except the use of drugs for legitimate medical purposes).

The Contractor shall further acknowledge and certify that it understands that a violation of these prohibitions constitutes a breach of contract and may result in default action being taken by the Commonwealth in addition to any criminal penalties that may result from such conduct.

I. UNIFORM ADMINISTRATIVE REQUIREMENTS

In accordance with 45 CFR § 74, the Contractor shall comply with all of the following Federal regulations.

1. Environmental Protection Rules

Each Contractor shall comply with all applicable standards, orders, or requirements issued under § 306 of the Clean Air Act (42 U.S.C. 7606, § 508 of the Clean Water Act [33 U.S.C. 1368]), which prohibits the use, under nonexempt Federal contracts, grants, or loans, of facilities included on the EPA List of Violating Facilities. The Contractor will report violations to the applicable Federal agency and the U.S. EPA Assistant Administrator for Enforcement.

2. Copeland "Anti-Kickback" Act

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 18 U.S.C. 874 and 40 U.S.C.276c, and as supplemented by Department of Labor regulations, 29 CFR Part 3. The Contractor shall report all suspected or reported violations to the applicable Federal agency.

3. Davis-Bacon Act

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 40 U.S.C. 276, and as supplemented by Department of Labor regulations, 29 CFR Part 5. The Contractor shall report all suspected or reported violations to the applicable Federal agency

4. Contract Work Hours and Safety Standards Act

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 40 U.S.C 327-333, and as supplemented by Department of Labor regulations, 29 CFR Part 5. The Contractor shall report all suspected or reported violations to the applicable Federal agency.

5. Rights to Inventions Made Under a Contract or Agreement

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 37 CFR Part 401.

6. Byrd Anti-Lobbying Amendment

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 31 U.S.C. 1352 and 45 CFR Part 93. No appropriated funds may be expended by the recipient of a Federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered Federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

7. Debarment and Suspension

Each Contractor shall comply with all applicable standards, orders, or requirements issued under Executive Orders 12549 and 12689, and 45 CFR part 76. Executive Order (E.O.) 12549 provides that, to the extent permitted by law, Executive departments and agencies shall participate in a government wide

system for nonprocurement debarment and suspension. A person who is debarred or suspended shall be excluded from Federal financial and non-financial assistance and benefits under Federal programs and activities. Debarment or suspension of a participant in a program by one agency shall have government wide effect.

8. Energy Policy and Conservation Act

The Contractor shall comply with any mandatory standards and policies relating to energy efficiency which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act, Public Law 94-163.

9. Rights to Inventions Made Under a Contract or Agreement

Contracts or agreements for the performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and State of Virginia in any resulting invention in accordance with 37 CFR part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any further implementing regulations issued by U.S. Department of Health and Human Services.

J. INSURANCE

Before delivering services under this Contract, the Contractor shall obtain the proper insurance coverage during the term of the Contract and ensure that all insurance coverage shall be provided by insurance companies authorized by the Virginia State Corporation Commission to sell insurance in the Commonwealth of Virginia. The Contractor shall have the following insurance coverage~~s~~ at the time the Contract is awarded and during the Contract period and annually submit documentation verifying coverage to the Department:

1. Professional Liability Insurance for the Contractor's Medical Director

Insurance in the amount of at least one million dollars ($1,000,000) for each occurrence shall be maintained by the Contractor for the Medical Director.

2. Workers' Compensation

The Contractor shall obtain and maintain, for the duration of this Contract, workers' compensation insurance for all of its employees working in the Commonwealth of Virginia. In the event any work is subcontracted, the Contractor shall require its subcontractor(s) similarly to provide workers' compensation insurance for all the latter's employees working in the Commonwealth. Any subcontract executed with a firm not having the requisite

workers' compensation coverage will be considered void by the Commonwealth of Virginia.

3. Employer's Liability

The Contractor shall maintain at least one hundred thousand dollars ($100,000) in liability coverage.

4. Commercial General Liability

The Contractor shall maintain five hundred thousand dollars ($500,000) in combined single-limit liability coverage. The Commonwealth of Virginia is to be named as an additional insured with respect to the services to be procured. This coverage is to include Premises/Operations Liability, Products and Completed Operations Coverage, Independent Contractor's Liability, and Personal Injury Liability.

5. Automobile Liability

The Contractor shall maintain five hundred thousand dollars ($500,000) per occurrence in automobile liability insurance for its corporate employees who use an automobile for business purposes.

K. TRANSITION

The Contractor shall provide for continuity of services, which is vital to the Department's overall effort to provide managed care services to its Medicaid/FAMIS Plus population. Continuity of service, therefore, must be maintained at a consistently high level without interruption. Upon expiration or termination of this Contract, a successor (i.e., another contractor) must continue these services and may need transitional assistance, such as training, transferring records and encounter data, etc. The Contractor shall, therefore, be required to prepare a transition plan to provide phase-in, phase-out services and cooperate in an effort to positively effect an orderly and efficient transition to a successor.

L. OMISSIONS

In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

M. WAIVER

No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the items of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

N. SEVERABILITY

If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to enrollees and if the remainder of this Contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

O. HEADINGS

The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

P. ASSIGNABILITY

Except as allowed under subcontracting, the Contract is not assignable by the Contractor, either in whole or in part, without the prior written consent of the Department.

Q. RIGHT TO PUBLISH

The Department agrees to allow the Contractor to write on subjects associated with the work under this Contract and have such writing published, provided the Contractor receives prior written approval from the Department before publishing such writings.

R. CONVENANT AGAINST CONTINGENT FEES

The Contractor shall warrant that no person or selling agency has been employed or retained to solicit and secure the Medallion II Contract upon an agreement or understanding for commission, percentage, brokerage, or contingency, excepting bona fide employees or selling agents maintained by the Contractor for the purpose of securing the business. For breach or violation of this warranty, the Commonwealth of Virginia shall have the right to cancel the Contract without liability or in its discretion, to deduct from the contract price or to otherwise

recover the full amount of such commission, percentage, brokerage, or contingency.

S. DELIVERY DATES FOR INFORMATION REQUIRED BY THE DEPARTMENT

When the last day for submission of any contractually required information or reports to the Department by the Contractor falls on a Saturday, Sunday or legal holiday, the information may be delivered on the next day that is not a Saturday, Sunday or legal holiday.

T. HIPAA DISCLAIMER

The Department makes no warranty or representation that compliance by the Contractor with this agreement or the HIPAA regulations will be adequate or satisfactory for the Contractor's own purposes or that any information in the Contractor's possession or control, or transmitted or received by the Contractor, is or will be secure from unauthorized use or disclosure, nor shall the Department be liable to the Contractor for any claim, loss or damage related to the unauthorized use or disclosure of any information received by the contractor from the Department or from any other source. The Contractor is solely responsible for all decisions made by the Contractor regarding the safeguarding of PHI.

ATTACHMENT I - AUTHORIZED WORKFORCE CONFIDENTIALITY AGREEMENT

This Agreement between _____ [the Contractor] and _____ (please print), an employee of _____ hereby acknowledges that [the Entity's] records and documents are subject to strict confidentiality requirements imposed by state and federal law including 42 CFR § 431 Subpart F, Virginia Code Section 2.1-377, et. seq.

I (initial) _____ acknowledge that my supervisor, or whoever administers the data, has reviewed with me the appropriate provisions of both state and federal laws including the penalties for breaches of confidentiality.

I (initial) _____acknowledge that my supervisor, or whoever administers the data, has reviewed with me the confidentiality and security policies of [the entity].

I (initial) _____acknowledge that my supervisor or, whoever administers the data, has reviewed with me the confidentiality and security policies of our organization.

I (initial) _____acknowledge that unauthorized use, dissemination or distribution of Virginia Department of Medical Assistance Services (DMAS) confidential information is a crime.

I (initial)_____hereby agree that I will not use, disseminate or otherwise distribute confidential records or said documents or information either on paper or by electronic means other than in performance of the specific job roles I am authorized to perform.

I (initial) _____also agree that unauthorized use, dissemination or distribution of confidential information is grounds for immediate termination of my employment or contract with [the entity] and may subject me to penalties both civil and criminal.

Signed Date_____

ATTACHMENT II - SUMMARY OF COVERED MEDALLION II (MEDICAID/FAMIS PLUS) SERVICES

This attachment is not intended to be a comprehensive list of benefits. All benefit limits should be verified through the appropriate DMAS Provider Manual.

Mental Health Services Are Listed At the End of this Summary Table				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid/FAMIS Plus Covered (see notes section)**	**Medallion II Covered**	**Notes**
Abortions, induced	12 VAC 30-50-100 and 12 VAC 30-50-40	No except in those cases where there would be substantial danger to health or life of mother	No	**The Contractor is not required to cover services for abortion**.
Case Management Services for Recipients of Auxiliary Grants	12 VAC 30-50-470	Yes	No	**The Contractor is not required to cover this service.** This service will continue to be covered through the DMAS fee-for-service system.
Case Management Services for the Elderly	12 VAC 30-50-460	Yes	No	**The Contractor is not required to cover this service**. This service will continue to be covered through the DMAS fee-for-service system.
Chiropractic Services	12 VAC 30-50-140	No	No	This service is not a Medicaid/FAMIS Plus covered service. **The Contractor is not required to cover this service.**
Christian Science Nurses and Christian Science Sanatoria	12 VAC 30-50-300	No	No	This service is not a Medicaid/FAMIS Plus covered service. **The Contractor is not required to cover this service.**
Clinic Services	12 VAC 30-50-180	Yes	Yes	The Contractor is required to cover all clinic services which are defined as preventative, diagnostic, therapeutic, rehabilitative, or palliative services, including renal dialysis clinic visits.
Colorectal Cancer Screening	12 VAC 30-50-220	Yes	Yes	The Contractor shall cover colorectal cancer screening in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.
Court Ordered Services	Code of Virginia Section 37.1-67.4	Yes	Yes	The Contractor is required to cover all medically necessary court ordered Medallion II services.
Dental Services	12 VAC 30-50-190 12 VAC 30-50-130	Yes	Yes	The Contractor is required to cover dental services for all enrollees under age 21. The Contractor is also required to cover limited oral surgery for adults as defined under Medicare. The Contractor is also required to cover dentures whenever determined necessary via an EPSDT screen. The contractor is also required to cover full-banded orthodontics and related services for recipients under the age of 21.

Mental Health Services Are Listed At the End of this Summary Table				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid/FAMIS Plus Covered (see notes section)**	**Medallion II Covered**	**Notes**
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	12 VAC 30-50-130	Yes	Yes	The Contractor is required to cover EPSDT screenings and diagnostic services as well as any and all services identified as necessary to correct or ameliorate any identified defects or chronic conditions. (Some services may require prior authorization) The Contractor is required to cover immunizations. The Contractor is required to educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates
Early Intervention	Virginia Code § 2.2-5300 12VAC30-130-10 and 12VAC30-50-200	Yes	Yes	The Contractor shall cover all medically necessary, Medicaid/FAMIS Plus covered services for children from birth to age three, who are determined eligible for Part C services of the Individuals with Disabilities Act by the Department of Mental Health Mental Retardation and Substance Abuse Services or applicable Early Intervention Interagency Council. The Contractor shall cover medically necessary services, including rehabilitative therapies within the amount duration and scope as defined in 12VAC30-130-10 and 12VAC30-50-200. All services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable. The Contractor or its designated subcontractor may require prior authorization of services for the purposes of determining medical necessity of therapies and services.
Emergency Services	12 VAC 30-50-110 12 VAC 30-50- 12 VAC 30-50-300 12 VAC 30-120-395	Yes	Yes	The Contractor is required to cover all emergency services without prior authorization. The Contractor is also required to cover the services needed to ascertain whether an emergency exists. The Contractor may not restrict an enrollee's choice of provider for emergency services.
Post Stabilization Care following Emergency Services	42 C.F.R. 422.100(b)(1)(iv)	Yes	Yes	The Contractor must cover post-stabilization services subsequent to an emergency that a treating physician views as medically necessary AFTER an emergency medical condition has been stabilized.

Mental Health Services Are Listed At the End of this Summary Table				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid/FAMIS Plus Covered (see notes section)**	**Medallion II Covered**	**Notes**
Experimental and Investigational Procedures	12 VAC 30-50-140	No	No	This service is not a Medicaid/FAMIS Plus covered service.
Family Planning Services	12 VAC 30-50-130	Yes	Yes	The Contractor is required to cover all family planning services and supplies for individuals of child-bearing age which delay or prevent pregnancy, including drugs, supplies and devices. The Contractor may not restrict an enrollee's choice of provider for family planning services or supplies, and the Contractor is required to cover all family planning services and supplies provided to its enrollees by network providers and by out-of-network providers.
HIV Testing and Treatment Counseling	Code of Virginia Section 54.1-2403.01	Yes	Yes	The Contractor is required to comply with the State requirements governing HIV testing and treatment counseling for pregnant women.
Home Health Services	12 VAC 30-50-160	Yes	Yes	The Contractor is required to cover home health services, including nursing services, rehabilitation therapies, and home health aide services. At least 32 home health aide visits shall be allowed. Skilled home health visits are limited based upon medical necessity.
Hospice Services	12 VAC 30-50-270	Yes	No	**The Contractor is not required to cover this service.** This service will continue to be covered through the DMAS fee-for-service system.
Immunizations	12 VAC 30-50-130	Yes	Yes	The Contractor is required to cover immunizations. The Contractor is required to educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates.

Mental Health Services Are Listed At the End of this Summary Table				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid/FAMIS Plus Covered (see notes section)**	**Medallion II Covered**	**Notes**
Inpatient Hospital Services	12 VAC 30-50-100 12 VAC 30-50-105 12 VAC 30-80-115 12 VAC 30-50-220 Chapter 709 of the 1998 Virginia Acts of Assembly § 32.1-325(A)	Yes	Yes	The Contractor is required to cover inpatient stays in general acute care and rehabilitation hospitals for all enrollees. The Contractor is required to comply with maternity length of stay requirements. Contractor is required to comply with radical or modified radical mastectomy, total or partial mastectomy length of stay requirements. The Contractor is required to cover an early discharge follow-up visit if the mother and newborn, or the newborn alone, are discharged earlier than 48 hours after the day of delivery.
Laboratory and X-ray Services	12 VAC 30-50-120	Yes	Yes	The Contractor is required to cover all laboratory and x-ray services directed and performed within the scope of the license of the practitioner.
Lead Investigations	12 VAC 30-50-227	Yes	No	**The Contractor is not required to cover this service**. This service will continue to be covered through the DMAS fee-for-service system.
Mammograms	12 VAC 30-50-220	Yes	Yes	Contractor is required to cover low-dose screening mammograms for determining presence of occult breast cancer
Medical Supplies and Equipment	12 VAC 30-50-160	Yes	Yes	The Contractor is required to cover all medical supplies and equipment at least to the extent they are covered by DMAS.
Mental Health Services (See last page of this table)				
Nurse-Midwife Services	12 VAC 30-50-260	Yes	Yes	The Contractor is required to cover nurse-midwife services as allowed under State licensure requirements and Federal law.

Mental Health Services Are Listed At the End of this Summary Table				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid/FAMIS Plus Covered (see notes section)**	**Medallion II Covered**	**Notes**
Organ Transplantation (Reference Table of Coverage shown in Article II.G.20.)	12 VAC 30-50-540 through 12 VAC 30-50-580, and 12 VAC 30-10-280 12 VAC 30-50-100G 12 VAC 30-50-105K	Yes	Yes	For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers (from living or cadaver donors) shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma when medically necessary. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.
Outpatient Hospital Services	12 VAC 30-50-110 -	Yes	Yes	The Contractor is required to cover preventive, diagnostic, therapeutic, rehabilitative or palliative outpatient services rendered by hospitals, rural health clinics, or federally qualified health centers. The Contractor is required to cover limited oral surgery as defined under Medicare.
Pap Smears	12 VAC 30-50-220	Yes	Yes	Contractor is required to cover annual pap smears
Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	12 VAC 30-50-200 12 VAC 30-50-225	Yes	Yes	The Contractor is required to cover physical therapy, occupational therapy, and speech pathology and audiology services that are provided as an inpatient or outpatient hospital service or home health service. The Contractor's benefits shall include coverage for acute and non-acute conditions and shall be limited based upon medical necessity.
Physician Services	12 VAC 30-50-140 -	Yes	Yes	The Contractor is required to cover all symptomatic visits to physicians or physician extenders and routine physicals for children up to age twenty-one under EPSDT.
Podiatry	12 VAC 30-50-150 -	Yes	Yes	The Contractor is required to cover podiatry services including diagnostic, medical or surgical treatment of disease, injury, or defects of the human foot.

Mental Health Services Are Listed At the End of this Summary Table				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid/FAMIS Plus Covered (see notes section)**	**Medallion II Covered**	**Notes**
Pregnancy-Related Services	12 VAC 30-50- 12 VAC 30-50- 12 VAC 30-50-510 12 VAC 30-50-410	Yes	Yes	The Contractor is required to cover case management services for high risk pregnant women and children (up to age two). The Contractor is required to provide to qualified enrollees expanded prenatal care services, including patient education; nutritional assessment, counseling and follow-up; homemaker services; and blood glucose meters. The Contractor is required to cover pregnancy-related and post-partum services for sixty (60) days after pregnancy ends.
Prescription Drugs	12 VAC 30-50-210 -	Yes	Yes	The Contractor is required to cover prescription drugs, including those prescribed by a provider during a physician visit or other visit covered by a third party payor including Mental Health visits.
Prostate Specific Antigen (PSA) and digital rectal exams	12 VAC 30-50-220	Yes	Yes	The Contractor is required to cover screening Prostate Specific Antigen (PSA) and the related digital rectal exams (DRG) for the screening of male enrollees for prostate cancer.
Prosthetics/Orthotics	12 VAC 30-50-210 12 VAC 30-60-120	Yes	Yes	The Contractor is required to cover prosthetics (arms and legs and their supportive attachments, breasts, eye prostheses) to the extent that they are covered under Medicaid. The Contractor is required to cover medically necessary orthotics for children under age 21 and for adults and children when recommended as part of an approved intensive rehabilitation program as described in 12VAC30-60-120.
Prostheses, Breast	12 VAC 30-50-210	Yes	Yes	The Contractor is required to cover breast prostheses following medically necessary removal of a breast for any medical reason.
Reconstructive Breast Surgery	12 VAC 30-50-140	Yes	Yes	Contractor is required to cover reconstructive breast surgery
Regular Assisted Living Services Provided to Residents of Assisted Living Facilities	12 VAC 30-120-450 12 VAC 30-120 12 VAC 30-120-470 12 VAC 30-120-480	No (auxiliary grant administered by DSS.)	No	**The Contractor is not required to cover this service.** When appropriate, the Department will reimburse the Assisted Living Facility as a carve-out payment. Reference the DMAS Assisted Living Facility Provider Manual for details.

Mental Health Services Are Listed At the End of this Summary Table				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid/FAMIS Plus Covered (see notes section)**	**Medallion II Covered**	**Notes**
School-health Services	12 VAC 30-50-229.1	Yes	No	The Contractor is not required to cover school-based services. School health services that meet the Department's criteria will continue to be covered as a carve-out service through the Medicaid/FAMIS Plus fee-for-service system. School-based services are defined under the DMAS school-based services regulations. The services are those therapy, skilled nursing, and psychiatric/psychological services as outlined in the Individual Education Plan (IEP) and rendered to children who qualify under the federal Individuals with Disabilities Education Act. The Contractor is responsible for covering EPSDT screenings for the general Medicaid/FAMIS Plus student population. Reference Article I. Definitions section for more details.
Skilled Nursing Facility Care	12 VAC 30-50-130 -	Yes	No	**The Contractor is not required to cover skilled nursing facility care**. This service will be covered through the DMAS fee-for-service system. Institutionalized individuals will become excluded from Medallion II upon entry into the DMAS nursing facility authorization database.
Temporary Detention Orders (TDOs)	42 CFR 441.150 and Code of Virginia 16.1-335 et seq	Yes	Yes	The Contractor is required to provide, honor, and be responsible for all requests for payment of services rendered as a result of a TDO for Mental Health Services.
Transportation	12 VAC 30-50-530 12 VAC 30-50-300	Yes	Yes	The Contractor is required to provide transportation to all Medicaid/FAMIS Plus covered services, including those Medicaid/FAMIS Plus services covered by a third party payor, and transportation to carved out services such as abortions and to services provided by subcontractors such as dental.
Vision Services	12 VAC 30-50-210	Yes	Yes	The Contractor is required to cover vision services including diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists and opticians. The Contractor is also required to cover eyeglasses under age 21. The Contractor's benefit limit for routine refractions shall not be less than once every twenty-four (24) months.

MENTAL HEALTH SERVICES				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid/FAMIS Plus Covered (see notes section)**	**Medallion II Covered**	**Notes**
Inpatient Mental Health Services				
Inpatient Mental Health Services Rendered in a Freestanding Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250	Yes	Yes	The Contractor is required to cover medically necessary inpatient psychiatric hospital stays for covered individuals over age sixty-four (64) or under age twenty-one (21).
Inpatient Mental Health Services Rendered in a Psychiatric Unit of a General Acute Care Hospital	12 VAC 30-50-100	Yes	Yes	Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all enrollees, regardless of age, within the limits of coverage prescribed in 12 VAC 30-50-105.
Inpatient Mental Health Services Rendered in a State Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250	Yes	No	**The Contractor is not required to cover this service**. This service will be covered through the DMAS fee-for-service system. Notify DMAS of all enrollee admissions to state mental hospitals.
Temporary Detention Orders (TDOs)	42 CFR 441.150 and Code of Virginia 16.1-335 et seq	Yes	Yes	The Contractor is required to provide, honor, and be responsible for all requests for payment of services rendered as a result of a TDO for Mental Health Services.
TREATMENT FOSTER CARE AND RESIDENTAL TREATMENT SERVICES FOR CHILDREN				
Treatment Foster Care (TFC) for children under age 21 years.	12VAC30-60-170 12VAC30-50-480 12VAC30-130-900 to 950	Yes	No	****DMAS authorization into a TFC program will result in disenrollment of the recipient from Medallion II. The TFC provider must contact WVMI for authorization.**
Residential Treatment Facility Services (RTF) for children under age 21 years	12VAC30-130-850 to 890	Yes	No	****DMAS authorization into a RTF program will result in disenrollment of the recipient from Medallion II. The RTF provider must contact WVMI for authorization.**

OUTPATIENT MENTAL HEALTH SERVICES The Contractor is responsible to cover outpatient mental health services. The benefit maximum for adults **in the first year of treatment** shall not be less than 52 visits, and 26 visits per year following the first year of treatment. For children under age 21 the benefit maximum is based upon medical necessity.				
Pyschiatric Diagnostic Exam	12VAC30-50-180 12VAC30-50-140	Yes	Yes	See the highlighted section above.
Individual Medical Psychotherapy	12VAC30-50-140, 12VAC30-50-150 and 12VAC30-50-180	Yes	Yes	See the highlighted section above.
Group Medical Psychotherapy	12VAC30-50-140, 12VAC30-50-150 and 12VAC30-50-180	Yes	Yes	See the highlighted section above.
Family Medical Psychotherapy	12VAC30-50-140, 12VAC30-50-150 and 12VAC30-50-180	Yes	Yes	See the highlighted section above.
Electoconvulsive Therapy	12VAC30-50-140, 12VAC30-50-150 and 12VAC30-50-180	Yes	Yes	See the highlighted section above.
Psychological/ Neuropsychological Testing	12VAC30-50-140, 12VAC30-50-150 and 12VAC30-50-180	Yes	Yes	See the highlighted section above.
Pharmacological Management	12VAC30-50-140, 12VAC30-50-150 and 12VAC30-50-180	Yes	Yes	See the highlighted section above.
COMMUNITY MENTAL HEALTH REHABILATATIVE SERVICES – STATE PLAN OPTION MENTAL HEALTH REHABILITATION SERVICES				
Community Mental Health Services	12VAC30-50-130 12VAC30-50-226 12VAC30-50-420 through 12VAC30-50-430	Yes	No	The MCO must provide information and referrals as appropriate to assist recipients in accessing these services. The MCO is required to cover transportation to and from SPO services and prescription drugs prescribed by the outpatient mental health provider.
Community Mental Retardation Services	12VAC30-50-440	Yes	No	The MCO must provide information and referrals as appropriate to assist recipients in accessing these services. The MCO is required to cover transportation to and from SPO services and prescription drugs prescribed by the outpatient mental health provider.

SUBSTANCE ABUSE TREATMENT SERVICES				
Out-patient substance abuse treatment		No	No	The Contractor is not required to cover substance abuse treatment services for Medicaid/FAMIS Plus enrollees.
Residential Treatment for Pregnant Women	12VAC30-50-510	Yes	No	The MCO must provide information and referral as appropriate to assist recipients in accessing this services. The MCO is required to cover transportation to and from Community MH SPO services and prescription drugs prescribed by the mental health provider.
Day Treatment for Pregnant Women	12VAC30-50-510	Yes	No	See comment directly above.

ATTACHMENT III - MCO ACTIVE PROVIDER FILE DATA REQUIREMENTS

FIELD NAME	DATA VARIATIONS / EXAMPLES
MCO Code*	Your number assigned by DMAS
Provider Type*	Examples are: Ancillary, CSB (Community Service Board), Dentist, Early Intervention, Health Department, Hospital, Independent Lab, OB/GYN, Optical, PCP, PCP – Pediatric, Pharmacy, Psychiatric
Provider Specialty*	Examples are: Anesthesiologist, Cardiologist, Dentist, DME, Hospital, Infectious Disease, Internal Medicine, OB/GYN, Pediatrician, Transportation, etc.
Provider Medicaid Number*	999999999
PCP Status*	Y or N
Provider Last Name*	Smith or ABC Hospital
Provider First Name	Robert or blank if facility name listed above
Address line 1*	123 Any Road
Address line 2	Suite 900
City*	Anywhere
State*	VA
Zip code*	99999
Phone area code	999
Phone number	999-9999
Phone extension	9999
24 Hour Access*	Yes or No
Other Language Spoken 1	Examples are: French, German, Italian, Russian, Spanish, etc.
Other Language Spoken 2	Examples are: French, German, Italian, Russian, Spanish, etc.
PCP maximum panel size**	2,500
PCP assigned panel size**	150
PCP limitations/restrictions**	Children Age 5-18, or No new patients, etc.
Tax ID*	999999999

* This field must be included for every record in the file.
** This field must be included for every PCP record in the file.

Notes:
The quarterly report to DMAS must be reported in an excel spreadsheet and must be provided electronically either via diskette or e-mail to the DMAS Managed Care Compliance Analyst.

The complete provider file; i.e., all PCPs, specialists, and subcontractor networks (this includes transportation, psychiatric, dental, optical, and/or pharmacy, etc.) must be submitted. The subcontractor network must include the complete listing of vendors with whom the subcontractor contracts to provide services to Medallion II program recipients.

The entire network should be in one file, formatted as above; not separate files or separate worksheets within one file. For providers with multiple office locations, each office location must be listed on a different line.

ATTACHMENT IV - DMAS FORM 213-MCO FOR NEWBORNS

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

NEWBORN ELIGIBILITY REPORT

MCO USE ONLY

ALL QUESTIONS MUST BE ANSWERED IN ORDER TO BE PROCESSED (Please Print Clearly)

*Mother's Name _____
Last First M.I.

*Mother's SSN ___ ___ ___ Date of Birth ___ ___ ___
M M D D Y Y

Mother's Address _____

_____

Mother's Medical Assistance Number_____

Mother's Telephone Number, if known_____

*Full Name of Newborn(s) Last	First	M.I.	*Birth Date MM/DD/YY	Sex	DSS Use Only MA Number Assigned

- **Note: Medicaid/FAMIS Plus eligibility for newborns begins on the date of birth, if the child is born to a Medicaid/FAMIS Plus eligible mother. Medicaid/FAMIS Plus newborms must be linked to their mother's case when enrolled in VAMMIS.**

Submitted by _____ **Signature** _____
Name and title

MCO Name _____ **Telephone #** _____
MCO Address _____
_____ **MCO Medicaid ID#**_____
_____

MAIL FORM IMMEDIATELY TO:
Local Department of Social Services That Handles Mother's Case

DSS Use Only
Date Received _____
Date Processed _____

DMAS FORM 213-MCO

***Required Information**

ATTACHMENT V - NETWORK PROVIDER AGREEMENT

A. RIGHT OF DEPARTMENT TO APPROVE, MODIFY OR DISAPPROVE NETWORK PROVIDER AGREEMENTS

The Department may approve, modify and approve, or deny network provider agreements under this Contract at its sole discretion. The Department may, at its sole discretion impose such conditions or limitations on its approval of an agreement as it deems appropriate. The Department may consider such factors as it deems appropriate to protect the interests of the Commonwealth and recipients, including but not limited to the proposed provider's past performance. The Contractor shall have no greater than one hundred and twenty (120) days to implement a change that requires the Contractor to find a new network provider, and sixty (60) days to implement any other change required by the Department, except that this requirement may be shortened by the Department if the health and safety of enrollees is endangered by continuation of an existing agreement. The Department will approve or disapprove an agreement within thirty (30) days after its receipt from the Contractor. The Department may extend this period by providing written notification to the Contractor if in the Department's sole opinion additional review or clarification is needed. Network provider agreements shall be deemed approved if the Department fails to provide notice of extension or disapproval within thirty (30) days.

The Department will review each type of agreement for services before contract signing. The Contractor shall initially submit each type of agreement for services with this Contract in the Attachments. The Department's review of the agreements will ensure that the Contractor has inserted the following standard language in all network provider agreements (except for specific provisions that are inapplicable in a specific Contractor management subcontract):

> (Contractor's name) (Hereafter referred to as "Contractor") and its intended Network Provider, (Insert Network Provider's Name) (hereafter referred to as "Provider"), agree to abide by all applicable provisions of the Contract (hereafter referred to as Medicaid/FAMIS Plus contract) with the Department of Medical Assistance Services. Provider compliance with the Medicaid/FAMIS Plus contract specifically includes but is not limited to the following requirements:

1. No terms of this agreement are valid which terminate legal liability of the Contractor in the Medicaid/FAMIS Plus Contract.

2. Provider agrees to participate in and contribute required data to Contractor's quality improvement and other assurance programs as required in the Medicaid/FAMIS Plus contract.

3. Provider agrees to abide by the terms of the Medicaid/FAMIS Plus contract for the timely provision of emergency and urgent care. Where applicable, the Provider agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency department Memorandums of

Understanding signed by the Contractor in accordance with the Medicaid/FAMIS Plus contract.

4. The Provider agrees to submit Contractor utilization data in the format specified by the Contractor, so the Contractor can meet the Department specifications required by Medicaid/FAMIS Plus contract.

5. The Provider agrees to comply with all non-discrimination requirements in Medicaid/FAMIS Plus contract.

6. The Provider agrees to comply with all record retention requirements and, where applicable, the special reporting requirements on sterilizations and hysterectomies stipulated in Medicaid/FAMIS Plus contract.

7. The Provider agrees to provide representatives of Contractor, as well as duly authorized agents or representatives of the Department, the U.S. Department of Health and Human Services, and the State Medicaid Fraud Unit access to its premises and its contract and/or medical records in accordance with Medicaid/FAMIS Plus contract. Provider agrees otherwise to preserve the full confidentiality of medical records in accordance with Medicaid/FAMIS Plus contract.

8. The Provider agrees to the requirements for maintenance and transfer of medical records stipulated in Medicaid/FAMIS Plus contract. Provider agrees to make medical records available to recipients and their authorized representatives within ten (10) working days of the record request.

9. The Provider agrees to ensure confidentiality of family planning services in accordance with Medicaid/FAMIS Plus contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act.

10. The Provider agrees not to create barriers to access to care by imposing requirements on recipients that are inconsistent with the provision of medically necessary and covered Medicaid/FAMIS Plus services.

11. The Provider agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts. Additionally the Provider agrees to hold the recipient harmless for charges for any Medicaid/FAMIS Plus covered service. This includes those circumstances where the provider fails to obtain necessary referrals, preauthorizations, or fails to perform other required administrative functions.

12. The Provider agrees not to bill a Medicaid/FAMIS Plus enrollee for medically necessary services covered under the Medicaid/FAMIS Plus contract and provided during the enrollee's period of Contractor enrollment. This provision shall continue to be in effect even if the Contractor becomes insolvent. However, if an enrollee agrees in advance of receiving the service and in writing to pay for a non-Medicaid/Non-FAMIS Plus covered service, then the Contractor, Contractor provider, or Contractor subcontractor can bill.

13. The Provider must forward to the Contractor medical records, within ten (10) working days of the Contractor's request.

14. The Providers shall promptly provide or arrange for the provision of all services required under the provider agreement. This provision shall continue to be in effect for subcontract periods for which payment has been made even if the provider becomes insolvent until such time as the enrollees are withdrawn from assignment to the provider.

15. Except in the case of death or illness, the Provider agrees to notify the Contractor at least thirty (30) days in advance of disenrollment and agrees to continue care for his or her panel enrollees for up to thirty (30) day after such notification, until another PCP is chosen or assigned.

16. The Provider agrees to act as a PCP for a predetermined number of enrollees, not to exceed the panel size limits set forth in Article II of this Contract, to be stated in the network provider agreement.

17. The Contractor agrees to pay the Provider within thirty (30) days of the receipt of a claim for covered services rendered to a covered enrollee unless there is a signed agreement with the Provider that states another timeframe for payment that is acceptable to that Provider.

18. Notwithstanding any other provision to the contrary, the obligations of Virginia shall be limited to annual appropriations by its governing body for the purposes of the subcontract.

B. NETWORK PROVIDER AGREEMENT SUPPLEMENT

The Department recognizes that the Contractor may use a Provider Manual as a supplement to the Provider Agreement. Under that condition, it must be understood that the Contract takes precedence over any language in the Provider manual. The Contract must reference the Provider Manual and identify it as part of the Provider Agreement. The Manual must contain language that states the Manual, revisions, and amendments to it are part of the Provider Agreement.

If the Contractor uses the Provider Manual as a supplement to the Provider Agreement, all sections pertaining to Medicaid/FAMIS Plus must be submitted to the Department for approval on an annual basis.

C. REVIEW AND APPROVAL OF NEW PROVIDER AGREEMENTS AND IN APPROVED SUBCONTRACTS DURING THE CONTRACT PERIOD

New agreements and changes in approved agreements shall be reviewed and approved by the Department before taking effect. Agreements will be considered approved if the Department has not responded within thirty (30) consecutive days of the date of Departmental receipt of request.

1. This review requirement applies to changes that affect the amount, duration, scope, location, or quality of services. In other words, technical changes do not have to be approved.

2. Changes in rates paid to subcontractors do not have to be approved. However, changes in method of payment (e.g., fee-for-service, capitation) must be approved by the Department.

3. The Contractor shall submit to the Department within thirty (30) days of the end of the quarter, addition or deletion of agreements involving: a clinic or group of physicians, an individual physician or facility.

4. Subcontracts with State Agencies or political subdivisions shall be excluded from the requirements of this addendum to the extent excluded elsewhere in the Contract.

ATTACHMENT VI - MCO INQUIRIES, GRIEVANCES AND APPEALS
MONTHLY SUMMARY REPORT

Reporting for the Month of _____

INQUIRIES		**Number**	**Per 1000**
TOTAL:			
SOURCE:	Members		
	Providers		
GRIEVANCES			
TOTAL:			
SOURCE:	Members		
	Providers		
TYPE:	Access		
	Utilization/Medical Management		
	Provider Care and Treatment		
	Payment and Reimbursement		
	Administrative		
STATUS:	Received		
	Resolved		
	Outstanding		
APPEALS			
TOTAL:			
TYPE:	Access		
	Utilization/Medical Management		
	Provider Care and Treatment		
	Payment and Reimbursement		
	Administrative		
STATUS:	Received		
	Resolved		
	Outstanding		

ATTACHMENT VII – SUMMARY OF REPORTING REQUIREMENTS

Contractor shall submit all reports through electronic format (CD, diskette, etc.) All submissions must comply with Code of Virginia §32.1-325, 12VAC30-20-90, §1902(a)(7) of the Social Security Act, and 42 CFR §431.300. The Contractor shall have in place appropriate administrative, technical and physical safeguards to ensure the security and confidentiality of records.

REPORTS	CONTRACT LOCATION	TIME FRAME
HEDIS Information	Art. II, L.	Annually
Breast Cancer Screening	Art. II, L.	Annually
Adolescent Well-Care Visit	Art. II, L.	Annually
Prenatal and Postpartum Care	Art. II, L.	Annually
Childhood Immunization Status	Art. II, L.	Annually
Adolescent Immunization Status	Art. II, L.	Annually
HEDIS/CAHPS 2.0H Adult Survey	Art. II, L.	Annually
Well-Child Visits in the First 15 Months of Life	Art. II, L.	Annually
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	Art. II, L.	Annually
Asthma Management Quality Study	Art. II, L.	Annually
Enrollee Info. Packet:	Art. II, D.	Annually
Introduction Letter	Art. II, D.	Annually
Sample ID Card	Art. II, E.	Annually
Provider Directory	Art. II, D.	Annually
EOC/Handbook	Art. II, D.	Annually
Updates to EOC, with cover letter explicitly identifying sections that have changed	Art. II, D.	Annually, as needed 30 days prior to planned use
Plan for High Risk Pregnant Women and Infants	Art. II, G.	Annually
High risk pregnancy women and infant outcomes and measurements	Art. II, G.	Annually
Percent of two year olds who have received each immunization specified by ACIP standards	Art. II, G.	Annually
Quality Improvement Program and Practice Guidelines	Art. II, L.	Annually
Mechanism for reporting any actions that seriously impact quality of care resulting in suspension or termination of practitioner's license to the appropriate authorities	Art. II, L.	Annually Defined in QIP Plan
Results of Internal Quality Studies	Art. II, L.	Annually and upon request
Prior Year's Outcomes (QIP)	Art. II, L.	Annually
Utilization Management Plan	Art. II, L.	Annually and upon revision
Referral guidelines that demonstrate the conditions under which PCPs make arrangements for referrals to specialty care networks.	Art. II, R.	Annually

REPORTS	CONTRACT LOCATION	TIME FRAME
Documentation detailing how a certification of need for services defined in 42 C.F.R. 441.152 is completed	Art. II, G.	(Annually) Prior to signing the contract and upon any change in procedures
Physician Incentive Plan (PIP)	Art. II, K.	Annually
Audit by Independent Auditor	Art. II, W.	Annually, within 30 calendar days of audit completion
If formulary established, formulary to be submitted for review	Art. II, G.	Annually and prior to the effective date for updates.
Pre-authorization requirements for formulary	Art. II, G.	Annually
Monitor and report a-typical utilization, providing number of requests and number of denials	Art. II, G.	Annually
Copy of health education and prevention plan, all member health education materials, including newsletters sent to members	Art. II, I.	Annually and prior to planned distribution
Process that is utilized to meet requirement that a toll free, 24 hour, 7 day a week, phone line, staffed by medical professionals to assist enrollees is in place	Art. II, J.	Annually
NCQA Accreditation Information	Art. II, A	If not accredited, seek accreditation within six months after start of this contract or thirty calendar days after becoming eligible to seek accreditation, whichever is later.
Report to DMAS any deficiencies noted within the previous year by NCQA	Art. II, A.	Within 30 calendar days of being notified of the deficiencies, or on the earliest date permitted by NCQA
Enrollee Health Education and Prevention Plan	Art. II, I.	Annually
Report on Sterilizations and Hysterectomies	Art. II, Q.	Annually
Marketing Plan	Art. II, C.	(Annually) Prior written approval
All enrollment, disenrollment and educational documents and materials made available to Medallion II enrollees	Art. II, F.	Annually
GAAP Accounting System	Art. II, A.	(Annually) Duration of Contract
Basis of Accounting used	Art. II, A.	(Annually) Prior to Contract Signature
License issued by State Corporation Commission	Art. II, A.	Annually Retain at all times. BOI issues annually
Data Certification	Art. 11, T, Att. XXIII, XXIV	Quarterly
REPORTS	**CONTRACT**	**TIME FRAME**

	LOCATION	
Network Provider Agreements	Attachment V	(Annually) & 15 days prior to effective date
Vision	Attachment V	(Annually) & 15 days prior to effective date
Dental	Attachment V	(Annually) & 15 days prior to effective date
Hospital	Attachment V	(Annually) & 15 days prior to effective date
Specialist	Attachment V	(Annually) & 15 days prior to effective date
Pharmacy	Attachment V	(Annually) & 15 days prior to effective date
Transportation	Attachment V	(Annually) & 15 days prior to effective date
Diagnostic/Lab	Attachment V	(Annually) & 15 days prior to effective date
Physician (PCP)	Attachment V	(Annually) & 15 days prior to effective date
Mental Health and Substance Abuse	Attachment V	(Annually) & 15 days prior to effective date
Organizational Chart that outlines Medallion II Operational Division	Art. II, Q.	Annually
Updated company background including awards, major changes, sanctions, etc.	Art. II, Q.	Annually
Updated subcontractor company background including awards, major changes, sanctions, etc.	Art. II, Q.	Annually
If Contractor uses the Provider Manual as a supplement to the Provider Agreement, all sections pertaining to Medallion II must be submitted	Attachment V	Annually
Written policies and procedures for the credentialing process that matches the credentialing and recredentialing standards from NCQA	Art. II, L.	Annually
Written policies and procedures governing the identification of newborns by network providers	Art. II, D.	Annually
Insurance Coverage	Art. XI, J	Annually
Written procedure for release of medical record information and obtaining consent for treatment	Art. II, M.	(Annually)

REPORTS	CONTRACT LOCATION	TIME FRAME

Policy and procedures related to the coordination of substance abuse treatment services with other providers and a mechanism whereby enrollees seeking or needing these services may obtain from the Contractor the Department's listing of appropriate provide	Art. II, G.	Annually
MCO Dental Utilization	Art. II, G	Annually
Program Integrity Plan (PIP) Policies and procedures for ensuring protection against actual or potential fraud and abuse	Art. II, T.	Annually
Procedures for enrollee transition to new PCP	Art. II, K.	(Annually) 30 calendar days prior to effective date of provider disenrollment
Written policies and procedures for assigning each of its enrollee to a PCP	Art. II, D	Annually
Written policies and procedures related to provider disenrollment	Art. II, K.	Annually
Policy and procedures for notifying PCPs of Panel Composition	Art. II, D	Annually, 5 business days of the date on which MCO receives enrollment report
Policy and procedures for In and Out-of Network providers can verify member enrollment	Art. II, D.	Annually, 5 business days of the date on which MCO receives enrollment report
Written Policies and Procedures which describe the grievance and appeals process and how it operates	Art. II, S.	Annually, Prior to implementation
Written policies and procedures and internal mechanisms for the prevention, detection and reporting of incidents of potential fraud and abuse by enrollees, by network providers, by subcontractors, and by the Contractor	Art. II, T.	Annually
Written policy and procedure for maintaining the confidentially of data, including medical records and enrollee information and appointment records for treatment of sexually transmitted diseases	Art. IX, B	Annually
Written policies and procedures addressing coordination of substance abuse services for pregnant women.	Art. II, G.	Annually
If Physician Incentive Plan found to be potentially cost avoidance by limiting referrals	Art. II, K.	(Annually) Contractor must demonstrate that all medically necessary referrals were authorized
Subcontractors for administrative services	Art. II, B.	(Annually) and 30 calendar days prior to effective date

REPORTS	CONTRACT LOCATION	TIME FRAME
Lab	Art. II, B.	(Annually) and 30 calendar days prior to effective date
Dental	Art. II, B.	(Annually) and 30 calendar days prior to effective date
Vision	Art. II, B.	(Annually) and 30 calendar days prior to effective date
Pharmacy	Art. II, B.	(Annually) and 30 calendar days prior to effective date
Mental Health	Art. II, B.	(Annually) and 30 calendar days prior to effective date
Transportation	Art. II, B.	(Annually) and 30 calendar days prior to effective date
After Hours Nurse Line	Art. II, B.	(Annually) and 30 calendar days prior to effective date
Enhanced Services	Art. II, G.	Annually and 30 calendar days prior to implementing or providing
Live Birth Outcomes Report	Art. II, D.	Quarterly
High Risk Maternity and Infant	Attachment II	Quarterly
Provider file to DMAS	Art. II, J	Quarterly
Disproportionate Share Hospital Report	Attachment II	Quarterly
BOI Financial Reports and any revisions	Art. II, A.	Quarterly - due same day sent to BOI (MCO must file within 45 days from end of quarter)
Submit any addition or deletion of agreements involving: a clinic or group of physicians, an individual physician or facility	Attachment V	Quarterly (within 30 days of the end of a quarter)
Returned ID Card List	Art. II, E.	Monthly
Date and number of ID cards mailed to new enrollees, each month	Art. II, E.	Monthly, on the 15th
Number of ID cards re-issued during the prior month	Art. II, E.	Monthly, on the 15th
Wait and Abandonment	Art. II, H.	Monthly
Electronic provider file to Enrollment Broker	Art. II, J.	Monthly
No Claim Activity Report	Art. II, L. Art. II. G.	Annually
MCO Report, includes:	Art. II, Q.	Monthly
90% of clean claims w/in		30 days of receipt
99% of all clean claims		Within 90 days of receipt
All other claims		12 months from receipt date
Monthly Enrollment		
Inpatient Authorizations		

REPORTS	CONTRACT LOCATION	TIME FRAME
PCP Availability		
Summary of inquires, grievances and appeals	Art. II, S.	Monthly on the 15th
Grievance Log	Art. II, S.	Monthly on the 15th
Appeal Log	Art. II, S.	Monthly on the 15th
Listing of all newborns that do not receive an identification number	Art. II, D.	Monthly, within 60 days
Provider network changes regarding termination, pending termination, or pending modification in the subcontractor's or network provider terms and not otherwise addressed in Attachment V, Section C for Medallion II	Art. II, J.	30 business days
Changes or modifications to policies and procedures for assigning enrollees to a PCP	Art. II, D.	30 calendar days prior to implementation
Changes to hospital contracts (if change impacts scope of covered services, number of individuals covered and/or units of service covered)	Art. II, J.	15 calendar days
Changes to key staff positions (lost and/or added)	Art. II, A.	Within 15 days of any change
Program or Site Change	Art. II, D.	14 calendar days prior to implementation
Type of arrangement established with FQHC or RHC	Art. IV., E.	Within 10 business days of establishing or changing
Standard Appeal Summary	Art. II, S.	Within 10 days prior to the date of the hearing
Expedited Appeal Summary	Art.II, S.	Within 4 business hours notice by the Department
Any enrollee discovered to have comprehensive health coverage	Art. IV, H.	Weekly Monthly
Any enrollee discovered to have workers' compensation coverage	Art. IV, H.	Monthly
Any enrollee who died and is over the age of 55	Art. IV, H.	Monthly
Any enrollee identified as having trauma injuries	Art. IV, H.	Weekly
Changes to/terminations of network provider agreements that could impact access to care	Art. II, J.	Within 7 days of change/termination
Acquisition Agreement, pre-merger agreement, proposed reorganization, or pre-sale agreement impacting the Contractor’s ownership.	Art. II.A.	Within 5 days of any such agreement.

REPORTS	CONTRACT LOCATION	TIME FRAME
Change in Ownership	Art. II, A.	5 calendar days prior to change
Prior Authorized Services Information for enrollees	Art. II, D.	Within 5 days upon request
Sanctions or changes in reserve requirements imposed by BOI or any other entity	Art. II, A.	2 business days
Report incidents of potential or actual fraud and abuse (of the Contractor, its network providers, or its enrollees)	Art. II, T.	Within 48 hours of initiation of any investigative action or within 48 hours of notification that another entity is conducting such an investigation.
Report incidents of potential or actual marketing services fraud and abuse	Art. II, T.	Immediately (within 48 hours of discovery of the incident)
Procedures for ensuring access to needed services for enrollees with disabling conditions, chronic illnesses, or child(ren) with special health care needs (e.g. Specialist to act as PCP).	Art. II, D.	As needed
Disclosure and justification of transactions between the Contractor and any Party of Interest	Art. II, A.	As required
Disclosure of all entities with which a Medallion II provider has an ownership or control relationship	Art. II, A.	As required
Coordinate and submit all its schedules, plans, and information materials for community education and outreach programs	Art. II, C.	As soon as possible
Provide supporting documentation that Contractor is paying FQHC or RHC at a comparable rate to other providers	Art. IV, E.	At the Department's request
System to monitor provider network to ensure access standards are met	Art. II, J.	Be prepared to demonstrate that these access standards have been met
Review the Contractor's policies and procedures and determine conditions for formal notification of situations involving quality of care	Art. II, L.	Department reserves the right
Actions taken by the Contractor to exclude, based on the provisions in Article II, Section K, an entity currently participating	Art. II, K.	Notify immediately
All new and/or revised marketing and information materials	Art. II, C.	Prior to their planned distribution

REPORTS	CONTRACT LOCATION	TIME FRAME
Subcontractors to submit for review and approval, all mass-generated letters intended for provider and/or enrollee distribution	Art. II, B.	30 days prior to their planned distribution
Changes in the Basis of Accounting used	Art. II, A.	Prior to Change
Changes to enrollee grievance and appeal procedures	Art. II, S.	Annually
Changes to the Education Plan	Art. II, I.	Prior to implementation
All incentive award packages	Art. II, C	Prior to implementation
Notify DMAS upon learning that an enrollee meets one or more of the exclusion criteria	Art. II, D.	Promptly
Create a Data Security Plan	Art. IX, C.	Work with Internal Audit

ATTACHMENT VIII – DISPROPORTIONATE SHARE HOSPITAL REPORT

This report must be completed for each hospital that received payment from the MCO during the contract period.

Hospital Name _____

City and State _____

Virginia Medicaid Number _____

		Total Days of Stay	Number of Discharges	Total Charges	Total Payments
1.	Adults and Pediatrics				
2.	Nursery including Preemie and Sick Baby Days				
3.	Neonatal Intensive Care				
4.	Psychiatric				
5.	Rehabilitation				
6.	Denied Days				

ATTACHMENT IX – LIVE BIRTH OUTCOMES REPORT

MCO Name:_____
DATE: _____

MCO Name	Mother's Last Name	Mother's First Name	Mother's Medicaid/FAMIS Plus Number	Mother's Effective Date in Plan	Mother's SSN or other ID Number	Mother enrolled in MCO's Prenatal Program?	Newborn's DOB	Newborn's Birth Weight (in grams)	Estimated Gestation period (in weeks)

ATTACHMENT X - CONFIDENTIALITY AGREEMENT FORM

This Agreement between the Virginia Department of Medical Assistance Services (DMAS) and _____ (Contractor) sets forth the terms and conditions for the disclosure of information concerning Medicare/Medicaid/FAMIS Plus applicants, recipients or providers (Data). For purposes of this Agreement, the Contractor includes any individual, entity, corporation, partnership, or otherwise, with or without a contractual agreement with DMAS, who has been granted permission by DMAS to use or to access Data in DMAS' possession.

Following execution of any contract with DMAS, the selected Contractor shall submit a written Security Plan, addressed to the DMAS HIPAA Office of Privacy and Security, describing the manner in which the Contractor will use DMAS Data and the procedures the Contractor will employ to secure that Data. DMAS HIPAA Office of Privacy and Security will work with the Contractor in the preparation of the Security Plan. The uses of DMAS Data detailed in the Security Plan shall not be in violation of purposes directly related to State Plan administration included in 42 C.F.R. § 431.302. The Contractor's Security Plan shall be eventually incorporated as Attachment 1 to this Agreement. No other uses of DMAS Data outside of the purposes stated in Attachment 1 will be allowed. The Contractor agrees to restrict the release of information to the minimum information necessary to serve the stated purpose described in the Security Plan. The Contractor agrees that there will be no commercial use of the DMAS data which it receives or creates in fulfillment of its contractual obligations.

The Contractor agrees to fully comply with all federal and state laws and regulations, especially 42 C.F.R. 431, Subpart F, and the Code of Virginia , Title 2.1, Chapter 26, (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Access to information concerning applicants or recipients must be restricted to persons who are subject to standards of confidentiality comparable to those DMAS imposes on its own employees and agents. The Contractor attests that the data will be safeguarded according to the provisions of the written, DMAS approved, Security Plan meeting the general requirements outlined in Attachment 2. The exact content of the Security Plan will be negotiated between the Contractor and DMAS HIPAA Office of Privacy and Security since the general data processing environment of each Contractor will be different. In no event shall the Contractor provide, grant, allow, or otherwise give, access to the Data in contravention of the requirements of its approved Security Plan. The Contractor assumes all liabilities under both state and federal law in the event that Data is disclosed in violation of 42 CFR 431, or in violation of any other applicable state and federal laws and regulations.

The Contractor shall dispose of all DMAS Data upon termination of the contract according to provisions for such disposal contained in its Security Plan. Contractor certifies that all Data, whether electronic or printed, in any form: original, reproduced, or duplicated, has been disposed of in accordance with the provisions of the Security Plan within thirty (30) days of completion of the project or termination of the contract. No copies, reproductions or otherwise, in whole or in part, in whatever form, of the Data shall be retained by the Contractor following

completion of the contract. The Contractor acknowledges that ownership of the Data remains with DMAS at all times.

A copy of all oral, written or electronic reports, presentations or other materials, in any form, whatsoever based, in whole or in part, on the Data must be reviewed and approved by DMAS prior to its release to any third party.

The Contractor will include, on the first page of all materials released to third parties, the following statement: "The following material may contain and may be based, in whole or in part, upon data provided by the Department of Medical Assistance Services, which retains all rights of ownership thereto. No copies or reproductions, electronic or otherwise, in whole or in part, of the following material may be made without the express written permission of the Department of Medical Assistance Services."

The Contractor acknowledges that DMAS reserves the right to audit for compliance with the terms of this agreement and for compliance with federal and state laws and regulations and for implementation of the terms of the approved Security Plan.

The Contractor hereby agrees to comply with all of the requirements set forth herein.

ATTACHMENT XI - DATA SECURITY PLAN ATTACHMENT

THIS ATTACHMENT supplements and is made a part of the Contract by and between the Department of Medical Assistance Services (herein referred to as "the Department") and [name Contractor] (herein referred to as "the Contractor").

I. General Requirements

The purpose of these requirements is to provide a framework for maintaining confidentiality and security of data compiled for the Department, the Contractor or its subcontractors. This data is the property of the Department.

The Contractor shall submit a written contractor Data Security Plan within thirty (30) days of the execution of this Agreement by general mail to the Department at the address in this contract. The Contractor's Data Security Plan shall describe the manner in which the Contractor will use the Department's data and the procedures the Contractor will employ to secure the data. The Department's HIPAA Office of Privacy and Security will work with the Contractor in the preparation of the Contractor's Data Security Plan. The uses of the Department's data detailed in the Contractor's Data Security Plan shall not be in violation of purposes directly related to State Plan administration included in 42 CFR § 431.302. No other uses of the Department's data outside of the purposes stated in the Contractor's Data Security Plan will be allowed. The Contractor agrees to restrict the release of information necessary to serve the stated purpose described in the Contractors Data Security Plan. The Contractor Associate agrees that there will be no commercial use or marketing use of the Department's data, which he or she receives or creates in fulfillment of his or her contractual obligations. Upon reasonable request, the Contractor shall give the Department access for inspection and copying to the Contractor's facilities used for the maintenance or processing of Protected Health Information (PHI), and to its books, records, practices, policies and procedures concerning the use and disclosure of PHI, for the purpose of determining the Contractor's compliance with this Agreement.

The Contractor agrees to fully comply with all federal and state laws and regulations, especially 42 CFR § 431, Subpart F, and Virginia Code Section 2.1-377, et. seq. Access to information concerning applicants or recipients must be restricted to individuals who are subject to standards of confidentiality comparable to those the Department imposes on its own workforce and vendors. The Contractor attests that the data will be safeguarded according to the provisions of the written, Department approved, contractor Data Security Plan meeting the general requirements outlined in Part II of this document. The exact content of the Contractor's Data Security Plan will be negotiated between the Contractor and the Department's HIPAA Office of Privacy and Security since the general data processing environment of each Contractor will be different. In no event shall the Contractor provide, grant, allow, or otherwise give access to the data in contravention of the requirements of its approved Contractor Data Security Plan. The Contractor assumes all liabilities under both state and federal law in the event that data is disclosed in violation of 42 CFR § 431, or in violation of any other applicable state and federal laws and regulations.

The Contractor shall dispose of all Department data upon termination of the contract according to provisions for such disposal contained in its Contractor Data Security Plan. The Contractor certifies that all data, whether electronic or printed, in any form: original, reproduced, or duplicated, has been disposed of in accordance with the provisions of the Contractor Data Security Plan within thirty (30) days of completion of the project or termination of the contract. No copies, reproductions or otherwise, in whole or in part, in whatever form, of the data shall be retained by the Contractor following completion of the contract. The Contractor acknowledges that ownership of the data remains with the Department at all times.

II. Format for a Basic Business Associate Data Security Plan

1. State the nature of the requesting organization's relationship with the Department Entity. In the absence of a contract or some other formal contractual relationship with the Department, please provide an explanation of how the proposed use of the Department's data is directly related to State Plan Administration [see 42 CFR § 431.302].

2. Provide the name of the Contractor's designated Information Security Officer, including full name, address, phone number and fax number. State the individual's relation to the business function.

3. Provide the names and position designations of all individuals who will have access to the data at or for the Contractor.

4. State the exact purpose(s) for which the data will be used.

5. Describe the format (e.g., tape, paper, disk or electronic transfer) in which the Contractor envisions receiving the required data from the Department.

6. Describe the medium within the Contractor's organization upon which the data will be stored (e.g., will the data be on a disk pack accessible by the Contractor's mainframe; will the data reside on a floppy disk stored in a box of similar disks beside the Contractor's PC; will the data be accessible to many users through a network on the Internet or on an Intranet?)

7. Describe the provisions the Contractor is taking to physically safeguard the Department data in whatever form it has been provided or created. As part of the Contractor Data Security Plan for the Department, the Contractor must include a copy of any security plan, security policies, or security procedures currently in effect within the organization.

8. Identify all individuals (or entities) to whom the data will be distributed as a result of the business function.

9. Describe through what mechanisms and in what format the Contractor proposes to make final work products available to the Department.

10. Summarize, within the Contractor's Data Security Plan, the data retention and disposal requirements that exist in the Contract or Agreements with the Department. If the Contractor is subject to any other retention requirements, those requirements should be included in the Contractor's Data Security Plan.

11. Provide a statement of acknowledgement in the Contractor's Data Security Plan that all Department data, no matter how manipulated or summarized remains the property of the Department.

12. Describe the provisions the Contractor is taking to ensure continuity of service to the Department in the event of an emergency or other catastrophic event causing contractor business interruption (where applicable).

13. Note the existence of any insurance or bonds carried by the Contractor, which would protect the Contractor and the Department from contingent liability in the use of the data. Otherwise, provide a statement in the Data Security Plan if no such insurance coverage exists.

DATA SECURITY PLAN EXAMPLE

XYZ ORGANIZATION BUSINESS ASSOCIATE DATA SECURITY PLAN

1. State the nature of the requesting organization's relationship with DMAS. In the absence of a Business Associate Agreement or some other formal contractual relationship with DMAS, please provide an explanation of how the proposed use of DMAS data is directly related to State Plan Administration (see 42 CFR, Section 431.302).

XYZ is the contractor for DMAS contract # XXXX_XX for Preauthorization and Utilization Management Services.

2. Provide the name of the Business Associate's designated Information Security Officer, including full name, address, phone number and fax number. State the individual's relation to the business function.

Name
Title
Organization
Address
Phone
Fax

Ms. Doe oversees all IT operations at XYZ including connectivity to and data transfer between the DMAS Medicaid Management Information System (MMIS) and XYZ.

3. Provide the names and position designations of all individuals who will have access to the data at or for the Business Associate.

Associates' name, title, department

4. State the exact purpose(s) for which data will be used.

1) Medical Review
2) Report Generation

5. Describe the format (e.g., tape, paper, disk) in which the Business Associate envisions receiving the required data from DMAS.

Data is submitted from providers by telephone, fax, or mail for medical review purposes and is entered into the internal XYZ databases. Information for all review cases is stored on a XYZ Windows 2000 based server with Oracle 8i as the database management system. Data are backed up to magnetic tape at the end of each business day and stored offsite at X location.

6. Describe the medium within the Business Associate's organization upon which the data will be stored (e.g., will the data be on a disk pack accessible by the Business Associate's mainframe; will the data reside on a floppy disk stored in a box of similar disks beside the Business Associate's PC; will the data be accessible to many users through a network on the Internet or on an Intranet?)

To ensure confidentiality and security, XYZ maintains a filing process that includes staff assigned for file maintenance, file retrieval, file purging and file preparation for offsite storage. XYZ provides DMAS with access to all files during normal hours of operation.

XYZ maintains file storage facilities for on-site review of the previous six months of documentation. XYZ maintains offsite storage for files older than 6 months at X storage facility. Files stored at this facility are returned to our location within 24 hours of the retrieval request. Emergency same-day retrieval service is also available.

Information pertaining to all requests is entered at the Windows 2000 desktop using Visual Basic developed screens and is stored on our Windows 2000 based server with Oracle 8i as the database management system. Data is backed up to magnetic tape at the end of each business day and stored offsite at x location. Access to the server for administrative purposes is limited to the Systems Manager, John Doe, and the Database Administrator, Jane Doe. User access to the

system and the case review data is controlled by Windows 2000 security provisions with additional access limitation imposed on the database side via Oracle. Both user ID's and passwords are required for access. Passwords are automatically aged by the system and must be changed by each user every thirty (30) days.

The Virginia Medicaid system is housed on a Hewlett Packard Pentium III 600 MHz server with 384k memory. Hard disk storage includes a RAID-5 disk array with four – 9.1 KB disk drives, a redundant power supply and tape backup. This system will have the same connectivity to DMAS MMIS as described above.

Data are never sent over the Internet. XYZ uses a secure 'internal' email system. Connectivity to our network is through a LAN in our Richmond office that then accesses our corporate email server via a dedicated frame delay connection line. We do not use Internet email facilities to send any DMAS information. Please refer to the response to question 7 for further information.

XYZ currently connects to the MMIS at x location via a frame-relay connection from our Richmond office to DMAS.

Future Operating Environment

As required by our new contract with DMAS we will eventually connect to MMIS at X location directly, rather than connecting at DMAS. We will use a serial connection between the XYZ provided CSU/DSU and the X router. Based on the expected volume, we will provide a 64 KBPS frame relay dedicated data line to the current DMAS Fiscal Agent's data center. In the event that traffic increases significantly, additional bandwidth can be added. At both ends of the frame relay data line, XYZ will provide an ADTRAN TSU LT T1/Fractional T1 CSU/DSU. A public address subnet will be provided if requested by Fiscal Agent for router-to-router connection. There will be a serial router port connection to the CSU/DSU on the Fiscal Agent side of the connection. As required, only public IP addresses will be presented across the data line. No connections across the Internet will be used.

XYZ will employ terminal emulation software – Eicon Access for Windows 3270 – to access the system from our desktop personal computers. Our existing employees and the DMAS contract monitors currently use this software to provide 3270 emulation for access to the DMAS computer system.

While our existing computer system easily and effectively handles all the processing required to support the DMAS requirements, every automated system can be improved. To reduce our maintenance costs, improve system access to DMAS authorized users and improve reliability, we are enhancing our existing Visual Basic/Oracle 8i Based computer system to a configuration that can also employ a browser-based client under Windows 95/98/2000. This browser-based

access will use a secure Virtual Private Network (VPN) connection to XYZ's Windows 2000 server supporting the Oracle 8i-database management system. This new environment will make it possible to extend access to the system to any DMAS approved user with access to the Internet, subject to encryption in the manner prescribed in the HCFA Internet Security Policy dated 11/24/1998.

Based on provider interest and approval of DMAS, we will develop ASP based forms to allow providers using their Internet connection to enter data about the pre-authorization request directly from their location – reducing or eliminating the need to fax this information to XYZ. Entry of information by the providers at the source of data to the XYZ maintained database means that errors and processing time associated with printing the fax, routing the fax to the appropriate reviewer and subsequent entry of the information to our computer system are eliminated.

7. Describe the provisions the Business Associate is taking to physically safeguard DMAS data in whatever form it has been provided or created. As part of the Business Associate Data Security Plan for DMAS, the Business Associate must include a copy of any security plan, security policies, or security procedures currently in effect within the organization.

Our data security and confidentiality plans are summarized and described below.

XYZ is well aware of the confidential nature of the information that we will receive and process, both in paper and electronic format. We also understand that all data provided by DMAS to XYZ remains the property of DMAS. We will use this data only for the activities needed to fully support all the requirements of this scope of work. In the event a need arises for use of the DMAS provided data for some other purpose, XYZ will obtain written permission from DMAS in advance of any use of this data. XYZ also agrees to follow federal and state confidentiality requirements as set forth in the then current Code of Federal Regulations and the then current Code of Virginia.

To ensure XYZ compliance with all of the confidentiality and security requirements associated with use and storage of health care information, all XYZ employees must adhere to the confidentiality rules and security procedures outlined in the XYZ Employee Notebook.

The notebook is updated as needed but at least every year to reflect current XYZ policies that its employees must adhere to. Every new employee is provided with a copy of the manual, and our Human Resources Department reviews the key section dealing with our confidentiality policy. This section includes information about:

- Access and disclosure of confidential information
- Responsibility for confidentiality vested in a single individual
- Research and statistical reporting

- Legal requests for information
- Disclosure, monitoring, review and evaluation
- Disclosure of privileged data and information to third parties
- Patient access to XYZ data and information
- Prospective employee background investigations
- Trustee and employee access and training
- Document accountability
- Building security
- Communications security, ADP security
- Subcontract requirements
- Responsibilities of medical review coordinators
- Requests for the generation of non-privileged information
- Penalties for disclosure of confidential information

HIPAA mandates new security standards to protect an individual's health information, while permitting the appropriate access and use of that information by health care providers, clearinghouses, and health plans. The standard mandates safeguards for physical storage and maintenance, transmission and access to individual health information regardless of the medium used. In addition to our institutionalization of confidentiality and security policies discussed above, XYZ will comply with all HIPAA data security requirements as needed.
These are some examples of steps we already have in place in:

- We have in place appropriate physical safeguards to protect data integrity, confidentiality and availability. Our offices are secure and require a key or swipe card for entry. Only XYZ employees and four DMAS contract monitors are granted these keys/cards. Visitors to XYZ facilities are required to register and wear visitor's passes. In addition a XYZ employee must escort them. Our computer servers and databases are housed in a locked room within our secure facility. Access to the computer room is limited to information technology personnel. XYZ employees escort maintenance personnel at all times. Smoke detectors and automated sprinkler systems are installed to protect from fire.

- We have developed and implemented administrative procedures to guard data integrity, confidentiality and availability. All employees are required to read and sign a non-disclosure agreement as a condition of employment. An employee handbook has been developed that details all employee responsibilities and acceptable conduct and the actions that may be taken in the event of improper conduct. Security awareness training is conducted periodically. All data is backed up on a daily basis and secured in a fireproof safe. Virus detection and correction software is installed on all PCs and corporate servers. Updates to this software are made on a bi-weekly basis.

- We have implemented technical security services to guard data integrity, confidentiality and availability. Access to our local area network and the services available on that network are limited to authorized users. The

program manager for each program grants authorization and a unique user id and password are used to gain access. Passwords are automatically retired every thirty (30) days. Access to the automated applications and underlying databases requires a separate logon and password. Access is further controlled on a "need" basis, providing either no access, read only, or write access to data. Users are automatically denied access following 3 failed logon attempts. System logs record user logon attempts, and applications capture information about who has added, modified or deleted records.

- Finally we have implemented appropriate technical security mechanisms that include the processes to prevent unauthorized access to data that is transmitted over a communications network. Our Systems Administrator, who grants access to users only upon program manager approval, controls access to our network. Currently, remote access to our local area network (and thence to the applications and databases) is highly restricted, and is used only from system administration. As we migrate our applications to a "web" ready environment, we will only support dial-in access (to users approved by DMAS) via a limited number of dial up circuits or via the Internet using Virtual Private Network (VPN) technology. VPN supports user authentication via public-private key exchange and provides a secure connection from the remote user to our systems over an encrypted "virtual tunnel" through the Internet.

To ensure that our security policies and practices remain current, we will periodically assess our security risks and vulnerabilities and the mechanisms currently in place to mitigate those risks and vulnerabilities. Measures in addition to those described above will be added as needed.

8. Identify all individuals (or entities) to whom the data will be distributed as a result of the business function.

Data that identify individual recipients, providers or facilities will never be distributed to any entity outside DMAS except with the express prior consent of DMAS. Aggregated data may be used for provider training, legislative presentations etc., but also only with the prior consent of DMAS. Data may occasionally be requested by HCFA or to other federal oversight authorities for inclusion in multi-state studies, analyses or for other purposes, but again, will not be released without the consent of DMAS.

9. Describe through what mechanisms and in what format the Business Associate proposes to make final work products available to DMAS.

XYZ will use the mechanisms and formats preferred by DMAS to make final work products available. This may include electronic transmission, tape, diskette, hard copy, or any other medium requested by DMAS.

Currently the weekly, monthly, quarterly annual and ad hoc reports are sent to DMAS electronically and/or in hard copy format. XYZ does not electronically send any reports to DMAS that contain patient identifiable information.

10. Summarize, within the Business Associate Data Security Plan, the data retention and disposal requirements that exist in the Contract or Agreements with DMAS. If the Business Associate is subject to any other retention requirements, those requirements should be included in the Business Associate Data Security Plan.

To ensure confidentiality and security, XYZ maintains a filing process that includes staff assigned for file maintenance, file retrieval, file purging and file preparation for offsite storage. XYZ provides DMAS with access to all files during normal hours of operation.

XYZ currently maintains file storage facilities onsite and available for review for the previous 6 months of documentation. XYZ maintains offsite storage for files older than 6 months at x storage facility. Files stored at this facility are returned to our location within 24 hours of the retrieval request. Emergency same-day retrieval service is also available.

XYZ shreds all hard copy data that is not stored for retrieval. Any removable magnetic media that has been used for storage is degausses before disposal.

11. Provide a statement of acknowledgement in the Business Associate Data Security Plan that all DMAS data, no matter how manipulated or summarized remains the property of DMAS.

XYZ is well aware of the confidential nature of the information that we will receive and process, both in paper and electronic format. We also understand that all data provided by DMAS to XYZ remains the property of DMAS. We will use this data only for the activities needed to fully support all the requirements of this scope of work. In the event a need arises for use of the DMAS provided data for some other purpose, XYZ will obtain written permission from DMAS in advance of any use of this data. XYZ also agrees to follow federal and state confidentiality requirements as set forth in the then current Code of Federal Regulations and the then current Code of Virginia.

12. Describe the provisions the Business Associate is taking to ensure continuity of service to DMAS in the event of an emergency or other catastrophic event causing Business Associate business interruption (where applicable).

XYZ has instituted a policy detailing our procedures for preauthorization during loss of connectivity. The following policies may be found in our XYZ -- Virginia Operations Policy and Procedures Manual and are also attached to this document.

- Utilization Review (Inpatient) Procedure for Loss of Connectivity.

- Utilization Management (Inpatient) Procedure for Loss of XYZ Database
- Prior-Authorization (Outpatient) Procedure for Loss of Connectivity
- Prior-Authorization (Outpatient) Procedure for Loss of XYZ Database
- Behavioral Health Review Procedure for Loss of Connectivity
- Behavioral Health Review Procedure for Loss of XYZ Database
- Community Based Care Review Procedure for Loss of Connectivity
- Community Based Care Review Procedure for Loss or XYZ Database

13. Note the existence of any insurance or bonds carried by the Business Associate, which would protect the Business Associate and DMAS from contingent liability in the use of the data. Otherwise, provide a statement in the Business Associate Data Security Plan if no such insurance coverage exists.

Our current Managed Care E&O Policy does cover "Medical Information Protection for claims arising out of the inadvertent release of medical information/records." Our underwriter is:

Name
Title
Organization
Address
License #
Phone
Fax

Attachments:
Enclosed are additional documents including Policies and Procedures that XYZ has issued in order to meet the guidelines of the Data Security Plan.

ATTACHMENT XII - THIRD PARTY ACCIDENT REPORT

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
FINANCIAL OPERATIONS, THIRD PARTY LIABILITY UNIT
RECIPIENT THIRD PARTY ACCIDENT REPORT

Person Providing Information_____
Telephone No.:_____

Member (Recipient) Name:_____
MEDICAID/FAMIS PLUS/SSN
NO.:_____
Accident Type and Date:_____
_____
_____
_____
_____

Firm/Company:_____
Firm/Company Address:_____
_____
_____
_____

MCO Name:_____
Prepared By:_____Date_____

ATTACHMENT XIII - GRIEVANCES AND APPEALS REASONS

1. ACCESS TO HEALTH CARE SERVICES

- Geographic access limitations to providers and practitioners
- Availability of PCPs/specialists/behavioral and mental health providers
- PCP after hour access
- PCP phone availability during office hours (no answer, lengthy hold, busy)
- Access to urgent care and emergency care
- Out-of-network access
- Availability and timeliness of provider appointments and provision of services
- Availability of outpatient services within the network (To include HHA, hospice, labs, physical therapy, radiation therapy)
- Enrollee provisions to allow transfers to other PCPs
- Patient abandonment by PCP
- Pharmaceuticals (Based upon patient's condition, the use of generic drugs versus brand name drugs)
- Access to preventative care (immunization, prenatal, STDs, alcohol, cancer, coronary, smoking)
- Access to MCO grievance and appeals procedures
- MCO enrollee notification regarding changes in the EOC and mandated benefits
- Transportation provider did not pick up member

2. UTILIZATION AND MEDICAL MANAGEMENT

- Denial of medically appropriate services covered within the enrollee contract
- Limitations on hospital length of stays for stays covered within the enrollee contract
- Timeliness of preauthorization reviews based on urgency
- Inappropriate setting for care, i.e., procedure done in an outpatient setting that should be performed in an inpatient setting
- Criteria for experimental care
- Unnecessary tests or lack of appropriate diagnostic tests
- Denial of specialist referrals allowed within the contract
- Failure to adequately document and make available to the members reasons for denial
- Unexplained death
- Denial of care for serious injuries or illnesses, the natural history of which, if untreated, are likely to result in death or to progress to a more severe form
- Organ transplant criteria questioned

3. PROVIDERS CARE AND TREATMENT

- Appropriateness of diagnosis and/or care
- Appropriateness of credentials to treat
- Failure to observe professional standards of care, state and or federal regulations governing health care quality
- Unsanitary physical environment
- Failure to observe sterile techniques or universal precautions
- Medical records-failure to keep accurate and legible records, to keep them confidential and to allow patient access
- Failure to coordinate care (Example: appropriate discharge planning)
- Rude and inappropriate treatment by provider
- Provider did not explain treatment
- Waited too long in office
- Discrimination

4. PAYMENT AND REIMBURSEMENT ISSUES

- Enrollee billed for covered services
- Enrollee charged inappropriately for co-payments
- Provider did not get paid promptly
- Provider claim denied inappropriately
- Provider claim processed incorrectly
- Enrollee billed for missed appointments

5. ADMINISTRATIVE ISSUES

- Did not receive member ID
- Enrollment, disenrollment decision not implemented
- Eligibility is wrong
- Incorrect information on member card
- Did not receive member handbook and/or other notices

ATTACHMENT XIV – SENTINEL EVENT REPORTING FORM

Use this form to report all sentinel events. Mail or Fax the completed form to:

Managed Care Contract Monitor
Division of Managed Care
Department of Medical Assistance Services
600 East Broad Street, 11th Floor
Richmond, VA 23219

FAX: (804) 786-5799
Phone: (804) 786-7346

1. MCO Name: _____
2. MCO Contact Person: _____
3. Contact Phone: _____
4. Recipient Full Name: _____
5. Recipient Medicaid/FAMIS Plus ID#: _____
6. Recipient Date of Birth: _____
7. Recipient Gender: Female_____ Male_____
8. Date of Death: _____
9. Providers: _____
   Hospital

   _____
   Primary Care Physician

   _____
   Specialist Physician or Other Provider
10. Cause of Death: _____
11. Source of sentinel event data _____

ATTACHMENT XV - HIGH RISK MATERNITY AND INFANT PROGRAM

Summary Information:

Reporting Period (Month, Year)	Total Maternity Cases Identified Reporting Period	Total Cases Contacted During Reporting Period	Total Cases Enrolled in Program During Reporting Period	Total Cases Unable to Contact During Reporting Period

Detail Information:

Recipient's Name	Medicaid/FAMIS Plus Number	Authorization Number	Description (Infant or Maternal)	Diagnosis

ATTACHMENT XVI - MANAGED CARE MONTHLY REPORT

MCO NAME

(MM-CCYY)

NUMBER OF ENROLLEES	

CLAIMS VOLUME	NUMBER
MONTH BEGIN INVENTORY	
RECEIVED THIS MONTH	
PROCESSED THIS MONTH	
MONTH END INVENTORY	

CLAIMS PROCESSED	NUMBER	PERCENT
NUMBER PAID THIS MONTH		
NUMBER DENIED THIS MONTH		
NUMBER PENDED THIS MONTH		
TOTAL		0.00

PROCESSING TIME FOR CLEAN CLAIMS (I.E. PAID AND DENIED CLAIMS)	PERCENT
PERCENT PROCESSED WITHIN 30 DAYS	
PERCENT PROCESSED IN 31-90 DAYS	
PERCENT PROCESSED IN 91-365 DAYS	
PERCENT PROCESSED OVER 365 DAYS	
TOTAL	0.00

INPATIENT AUTHORIZATIONS	NUMBER	PERCENT
NUMBER APPROVED		
NUMBER REDUCED		
NUMBER DENIED		
TOTAL NUMBER REQUESTED	0	0.00

PRIMARY CARE PHYSICIANS	NUMBER	PERCENT
NUMBER WITH OPEN PANELS		
NUMBER WITH CLOSED PANELS		
NUMBER WITH RESTRICTED PANELS		
TOTAL	0	0.00

ATTACHMENT XVII - FACILITY PAYMENT LAYOUT

The electronic file that the Managed Care Organization (MCO) will submit to the Department of Medical Assistance Services (DMAS) for claims paid by the MCO will have the following data elements described below. This file shall be created after each remittance processing cycle and forwarded to DMAS in an appropriate fashion such as, direct encrypted electronic transmission, compact disc (CD), compatible magnetic tape, floppy disc or other mutually agreed upon transmission media. The provider shall submit the data in either columnar flat file (left justified, *.TXT) or PCSAS Version 8.0 or later CPORT (*.STX) format.

Variable	Type	Len	Format	Label
ACT_DATE	Char	8		FILE/CREATE/DATE/YYYYMMDD
ADM_DATE	Char	8		ADMIT/DATE/PT/YYYYMMDD
ADM_DIAG	Char	5		ADMIT/DIAG/PT
ATTND_MD	Char	7		ATTEND/PHYSICIAN
CO_PAY	Num	11	DOLLAR11.2	PATIENT CO/PAY
COV_CHG	Num	12	DOLLAR12.2	COVERED/CHARGES
COV_DAYS	Num	3		COVERED/ DAYS
CTY_CNTY	Char	3		CITY/COUNTY PROVIDER FIPS CODE
DISCHGST	Char	2		DISCHARGE/ STATUS
DRG	Char	5		DIAGNOSIS RELATED GROUP
FORM_REF	Char	10		FORMER/REFERENCE
FROM_DTE	Char	8		FROM/DATE OF SERVICE/YYYYMMDD
MI	Char	3		MIDDLE INITIAL PATIENT
NAME_FST	Char	20		FIRST NAME PATIENT
NAME_LST	Char	30		LAST NAME PATIENT
PAT_PAY	Num	11	DOLLAR11.2	PATIENT/PAYMENT
PAY_MCO	Num	11	DOLLAR11.2	MCO/PAYMENT/TO/PROVIDER
DRG_DAYS	Num	3		DRG/PAYMENT/DAYS
PRN_DATE	Char	8		PRIN/PROCEDURE/DATE/YYYYMMDD
PRN_DIAG	Char	5		PRINCIPAL/DIAGNOSIS
PRN_PROC	Char	5		PRINCIPAL/PROC/CODE
PROVIDER	Char	7		PROVIDER/MEDICAID/NUMBER
RECIP	Char	12		RECIPIENT/MEDICAID/NUMBER
REF_NUM	Char	10		REFERENCE/UNIQUE/CLAIM/NUMBER
REMIT_DT	Char	8		CLAIM/REMIT/DATE/YYYYMMDD
SSN	Char	12		SOCIAL/SECURITY/NUMBER
STATUS	Char	1		STATUS/MCO/PAID UNPAID
THRU_DTE	Char	8		THRU/DATE/OF/SERVICE/YYYYMMDD

ATTACHMENT XVIII - MEDALLION II OPEN ENROLLMENT EFFECTIVE DATES BY REGION

CENTRAL VIRGINIA REGION FEBRUARY AND MARCH - EFFECTIVE APRIL 1					
001	ACCOMACK	081	GREENSVILLE	133	NORTHUMBERLAND
007	AMELIA	085	HANOVER	135	NOTTOWAY
025	BRUNSWICK	087	HENRICO	730	PETERSBURG
033	CAROLINE	670	HOPEWELL	145	POWHATAN
036	CHARLES CITY	097	KING AND QUEEN	147	PRINCE EDWARD
041	CHESTERFIELD	099	KING GEORGE	149	PRINCE GEORGE
570	COLONIAL HEIGHTS	101	KING WILLIAM	760	RICHMOND CITY
049	CUMBERLAND	103	LANCASTER	159	RICHMOND COUNTY
053	DINWIDDIE	111	LUNENBURG	175	SOUTHAMPTON
595	EMPORIA	115	MATHEWS	177	SPOTSYLVANIA
057	ESSEX	117	MECKLENBURG	179	STAFFORD
620	FRANKLIN CITY	119	MIDDLESEX	181	SURRY
630	FREDERICKSBURG	127	NEW KENT	183	SUSSEX
075	GOOCHLAND	131	NORTHAMPTON	193	WESTMORELAND
TIDEWATER REGION MAY AND JUNE - EFFECTIVE JULY 1					
550	CHESAPEAKE	700	NEWPORT NEWS	810	VIRGINIA BEACH
073	GLOUCESTER	710	NORFOLK	830	WILLIAMSBURG
650	HAMPTON	735	POQUOSON	199	YORK
093	ISLE OF WIGHT	740	PORTSMOUTH		
095	JAMES CITY COUNTY	800	SUFFOLK		
NORTHERN AND CULPEPER REGIONS JULY AND AUGUST - EFFECTIVE SEPTEMBER 1					
510	ALEXANDRIA	059	FAIRFAX COUNTY	683	MANASSAS CITY
013	ARLINGTON	610	FALLS CHURCH	685	MANASSAS PARK
047	CULPEPER	061	FAUQUIER	153	PRINCE WILLIAM
600	FAIRFAX CITY	107	LOUDOUN		
WESTERN AND SOUTHWESTERN REGIONS SEPTEMBER AND OCTOBER - EFFECTIVE NOVEMBER 1					
003	ALBEMARLE	071	GILES	143	PITTSYLVANIA
015	AUGUSTA	079	GREENE	155	PULASKI
515	BEDFORD CITY	083	HALIFAX	750	RADFORD
019	BEDFORD COUNTY	660	HARRISONBURG	770	ROANOKE CITY
023	BOTETOURT	089	HENRY	161	ROANOKE COUNTY
029	BUCKINGHAM	678	LEXINGTON	163	ROCKBRIDGE
530	BUENA VISTA	109	LOUISA	165	ROCKINGHAM
037	CHARLOTTE	113	MADISON	775	SALEM
540	CHARLOTTESVILLE	690	MARTINSVILLE	790	STAUNTON
590	DANVILLE	121	MONTGOMERY	820	WAYNESBORO
063	FLOYD	125	NELSON	197	WYTHE
065	FLUVANNA	137	ORANGE		
067	FRANKLIN COUNTY	141	PATRICK		

ATTACHMENT XIX – MONTHLY EDI REPORT FOR ENROLLMENT BROKER

MCO Provider File

File PS-F-025

FIELD NAME	PICTURE	FLD	START	END	LENGTH	DESCRIPTION
P025-PROV-MCO-RECORD			1	235	235	
P025-MCO-TRANS-CODE	X	1	1	1	1	A code that designates the type of action this record represents
P025-MCO-ID	9(9)	2	2	10	9	A unique identification number assigned to a provider
FILLER	XX	3	11	12	2	
P025-PROV-ID	9(9)	4	13	21	9	A unique identification number assigned to a provider
P025-PROV-TYPE	999	5	22	24	3	A code that designates the classification of a provider under the State plan (e.g., Dentist, Pharmacy)
P025-PROV-SPEC	999	6	25	27	3	The provider's certified medical specialty(ies)
P025-PROGRAM-CODE	99	7	28	29	2	The program(s) in which a provider participates 01 Medicaid 02 MEDALLION 03 Medallion II 04 Options (MCO) 05 CMM 06 TDO 07 SLH 08 FAMIS 09 Assisted Living
P025-PROV-NAME	X(60)	8	30	89	60	The name of the provider
P025-ADDRESS	X(60)	10	90	149	60	The street in the address of the provider
P02----------5-CITY	X(30)	11	150	179	30	The city in the address for the provider
P025-ZIPCODE	9(9)	12	180	188	9	The Zip code in the address of the provider
P025-PHONE-NUM	9(10)	13	189	198	10	The provider's phone number
P025-PHONE-NUM-EXT	9(4)	14	199	202	4	The phone number extension for a provider
FILLER	X(33)	15	203	235	33	

ATTACHMENT XX – ANNUAL NOTICE OF HEALTH CARE RIGHTS
(English Translation)

Español
Tiếng Việt
فارسی
?  ?
1-800-643-2273
हिन्दी
اللغة العربية
한국말

ANNUAL NOTICE OF HEALTH CARE RIGHTS

You have the RIGHT to ask your Managed Care Organization (MCO):

- What medical services your MCO offers.
- How to get covered services that your MCO does not offer.
- How to get a referral for specialty care and other services not provided by your primary care doctor (PCP).
- How to get approval from your MCO to see doctors who are not in your MCO.
- What to do if you have a medical emergency or need medical advice after office hours.
- How to make an official complaint about your MCO or appeal a medical decision by your MCO directly to the Department of Medical Assistance Services (DMAS).
- How to get information about your MCO's doctors, other providers, translation services or transportation.

You have the RIGHT to:

- Have access to health care services
- Receive information about your health care and see your medical records
- Be involved in decisions about your health care
- Receive information about treatment options or other types of care
- Be treated with respect, consideration and dignity
- Expect all information about your health to be confidential
- Tell DMAS about any problems you are having with your MCO
- Change your MCO once a year for any reason during open enrollment
- Change your MCO after open enrollment for an approved reason
- Make an official complaint with your MCO or appeal directly to DMAS

You also MUST:

- Present your MCO Membership Card whenever you seek medical care
- Provide complete and accurate information on your health and medical history
- Follow your MCO's rules for getting services and follow your doctor's instructions
- Schedule appointments, be on time, and notify your doctor if you are late or must cancel
- Call the Department of Social Services (DSS) to report any changes such as address, phone number and other personal information (birth, marriage, death, other health insurance, or income changes)

If you have any questions on managed care or your health care rights, call your MANAGED CARE HELPLINE at
1-800-643-2273

ATTACHMENT XX – ANNUAL NOTICE OF HEALTH CARE RIGHTS
(Back - Spanish Translation)

Español
Tiếng Việt
فارسی
? ?
1-800-643-2273
हिन्दी
اللغة العربية
한국말

ANNUAL NOTICE OF HEALTH CARE RIGHTSAVISO ANUAL DE DERECHOS DE ATENCIÓN MÉDICA

Usted tiene el DERECHO de preguntar a su Organización de Cuidados Administrados (MCO – Managed Care Organization):

- Qué servicios médicos ofrece su MCO.
- Cómo obtener servicios cubiertos que su MCO no ofrezca.
- Cómo obtener un referimiento para atención especializada y otros servicios no provistos por su proveedor de cuidados primarios (PCP).
- Cómo obtener la aprobación de su MCO para que lo(a) atiendan médicos que no pertenezcan a su MCO.
- Qué hacer cuando tenga una emergencia médica o necesite consejo médico fuera de horario de atención.
- Cómo presentar una queja oficial de su MCO o apelar a una decisión médica realizada por su MCO directamente al Departamento de Servicios de Asistencia Médica (DMAS – Department of Medical Assistance Services).
- Cómo obtener información sobre los médicos, otros proveedores, servicios de traducción o transporte de su MCO.

Usted tiene el DERECHO de:

- Obtener acceso a servicios de cuidado de la salud
- Recibir información sobre su atención médica y ver sus registros médicos
- Participar en las decisiones sobre su atención médica
- Recibir información sobre opciones de tratamiento u otros tipos de cuidado
- Ser tratado(a) con respeto, consideración y dignidad
- Esperar que toda la información relacionada con su salud sea confidencial
- Informar al DMAS sobre cualquier problema que pudiera tener con su MCO
- Cambiar de MCO una vez al año, por cualquier motivo, durante la inscripción abierta
- Cambiar de MCO después de la inscripción abierta por un motivo aprobado
- Presentar una queja oficial a su MCO o apelar directamente al DMAS

Usted también DEBE:

- Presentar su Tarjeta de Miembro del MCO siempre que reciba atención médica
- Proveer informaciones completas y precisas sobre su historia de salud y médica
- Respetar las reglas del MCO para la obtención de servicios y seguir las instrucciones de su médico
- Marcar citas, llegar en horario y notificar a su médico si se atrasará o necesita cancelar la cita
- Llamar al Departamento de Servicios Sociales (DSS – Department of Social Services) para informar sobre cualquier cambio, tal como de dirección, número de teléfono y otras informaciones personales (nacimiento, casamiento, fallecimiento, otro seguro de salud o cambios en sus ingresos)

Si tiene dudas sobre cuidados administrados o sobre sus derechos de atención médica, llame a nuestra LÍNEA DE AYUDA DE CUIDADOS ADMINISTRADOS al 1-800-643-2273

ATTACHMENT XXI – HEALTH STATUS SURVEY QUESTIONNAIRE

I would like to ask you some questions about your health and the health of any other MCO members in your house. The information you give me will go to the MCO. It's helpful for the MCO to know something about their new members so they can begin planning for your care. Do you have a minute to answer these questions?

Some of these questions are personal, and your answers will be confidential and private—only the MCO will get this information.

Please answer for yourself and everyone in your house who is a member of the MCO.

Case Head		Case Head SSN		Case Head Language:
Last Name		First Name		Medicaid ID#
Address		City	State/Zip	Ph#
1	Gender			☐ Male ☐ Female
2	Date of Birth			
3	What MCO are you choosing?		Name:	
4	Do you have a doctor you want to be your Primary Care Provider?		Name:	
5	If you have a regular doctor now, what is the doctor's name?		Names:	
6	Are you seeing any specialists (doctors who specialize in a particular field of medicine, such as a cardiologist)? (If yes) What are the names?		☐ Yes ☐ No List:	
7	Are you taking medicines that a doctor has prescribed? [If yes, ask what they are and what they're for.]		☐ Yes ☐ No List:	
8	Are you using any durable medical equipment, such as a hospital bed, oxygen, a wheelchair, a breathing machine—anything like that? If yes, did a doctor prescribe it?		☐ Yes ☐ No What: ☐ Yes ☐ No	
9	Are you pregnant? [If yes], ▪ When is the baby due? ▪ Does the doctor have any special concerns about this pregnancy?		☐ Yes ☐ No Date:	
	Now I'm going to read a list of health problems, and you tell me if you or anyone in the family has that problem.			
10	Do you have surgery planned for the future? If yes, what is the date of surgery?		☐ Yes ☐ No Date:	
11	Are you getting home care or home hospice care? If yes, please explain.		☐ Yes ☐ No Explanation:	
12	Are you on an organ transplant list? If yes, please explain.		☐ Yes ☐ No Explanation:	
15	Are you getting physical therapy, or occupational therapy, or speech therapy?	☐ Yes ☐ No		

ATTACHMENT XXI – HEALTH STATUS SURVEY QUESTIONNAIRE
(Continued)

16	Do you have a heart condition--such as congestive heart failure?	☐ Yes ☐ No
17	Do you have a lung disorder--such as asthma or COPD?	☐ Yes ☐ No
18	Are you being treated by a psychiatrist or psychologist?	☐ Yes ☐ No
19	Do you have diabetes?	☐ Yes ☐ No
20	High blood pressure?	☐ Yes ☐ No
21	Do you have kidney disease or are you on dialysis?	☐ Yes ☐ No
22	Do you have cancer?	☐ Yes ☐ No
23	Do you smoke?	☐ Yes ☐ No
24	Are you living with HIV or AIDS?	☐ Yes ☐ No
25	Do you have a blood disease, such as sickle cell anemia or Hepatitis?	☐ Yes ☐ No
26	Do you have tuberculosis (TB)?	☐ Yes ☐ No
27	Are any children in the house in ▪ Part C services, care coordination for children ▪ Any health department program, or ▪ Do any children receive Case Manager or Care Coordination services?	☐ Yes ☐ No List program and/or care coordinator:
28	Can you think of any other special medical or mental health needs that the MCO might want to know about?	☐ Yes ☐ No List:
29	Have you been in the hospital in the last 12 months? [If yes] Why were you admitted?	☐ Yes ☐ No Reason:
30	What is your height?	Feet_____inches_____
31	And your weight?	Pounds

Thank you for taking the time to answer these questions. I'll give this information to your new MCO, and they will be in touch with you soon.
If you have any questions or need assistance, please call the Managed Care Helpline at 1-800-MGD-CARE or 1-800-643-2273.

Center for Health Literacy 2
January 7, 2003

ATTACHMENT XXII - CERTIFICATION OF ENCOUNTER DATA

RELATING TO PAYMENT UNDER THE MEDICAID PROGRAM

CERTIFICATION

Pursuant to the contract(s) between Virginia and the (enter name of business entity) managed care organization (MCO), the MCO certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the Virginia Medical Assistance Program as a MCO, (insert Plan identification number(s) here). The (enter name of business) MCO acknowledges that if payment is based on encounter data, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The MCO hereby requests payment from the Virginia Medical Assistance Program under contracts based on encounter data submitted and in so doing makes the following certification to Virginia as required by the Federal regulations at 42 CFR 438.600 (et.al.).

The (enter name of business) MCO has reported to Virginia for the month of (indicate month and year) all new encounters (indicate type of data such as – Mental Health – Institutional, Mental Health – Professional, Medical – Institutional, Medical – Professional, Pharmacy, Transportation, Dental, Vision, Laboratory). The (enter name of business) MCO has reviewed the encounter data for the month of (indicate month and year) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to Virginia in this report is accurate, complete, and truthful.

NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO THE (Enter Name of Business) MCO. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT.

_____

(INDICATE NAME AND TITLE (CFO, CEO, OR DELEGATE)

on behalf of

_____

(INDICATE NAME OF BUSINESS ENTITY)

_____

DATE

ATTACHMENT XXIII - CERTIFICATION OF DATA (NON-ENCOUNTER)

CERTIFICATION

Pursuant to the contract(s) between Virginia and the (enter name of business entity) managed care organization (MCO), the MCO certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the Virginia Medical Assistance Program as a MCO Plan, (insert Plan identification number(s) here). The (enter name of business) MCO acknowledges that if payment is based on any information required by the State and contained in contracts, proposals, and related documents, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The MCO hereby requests payment from the Virginia Medical Assistance Program under contracts based on any information required by the State and contained in contracts, proposals, and related documents submitted and in so doing makes the following certification to Virginia as required by the Federal regulations at 42 CFR 438.600 (et.al.).

The (enter name of business) MCO has reported to Virginia for the period of (indicate dates) all information required by the State and contained in contracts, proposals, and related documents submitted. The (enter name of business) MCO has reviewed the information submitted for the period of (indicate dates) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to Virginia is accurate, complete, and truthful.

NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO THE (Enter Name of Business) MCO. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT.

_____

(INDICATE NAME AND TITLE (CFO, CEO, OR DELEGATE)

on behalf of

_____

(INDICATE NAME OF BUSINESS ENTITY)

_____

DATE

ATTACHMENT XXIV - MCO SPECIFIC CONTRACT TERMS
XXX MCO

1. Cities/counties in which enrollment is accepted:

TIDEWATER	RICHMOND/ CHARLOTTESVILLE	RURAL	RURAL (CONTINUED)
Other Metropolitan Statistical Area (MSA)			

2. Maximum enrollment level: to be determined by DMAS.

3. This contract shall become effective on July 1, 2004 and continue to June 30, 2005.

4. Capitation Rate: For the areas listed above, the Contractor shall receive two (2) separate payments, where the total sum is equal to the capitation rate described in Attachment XXVII~~XXIII.II~~ [CDPS Adjusted Rate]. First, the Contractor shall receive the MMIS generated payment as outlined in Attachment XXV.I. In addition, the Contractor shall receive a second payment equal to the difference between the CDPS adjusted rate [Attachment XXV.III], and the MMIS generated payment [Attachment XXV.I]. The second "differential" payment rate is outlined in Attachment XXV.III, will be rendered by separate check and will follow the distribution of the monthly capitation payment.

** *Areas where Medallion II is operating with one (1) contracted MCO.*

ATTACHMENT XXIV – MCO SIGNATURE PAGE
XXX MCO
(Continued)

IN WITNESS HEREOF, the parties have caused this Contract to be duly executed intending to be bound thereby.

CONTRACTOR:	**COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**
MCO INC.	
By:_____	**By:**_____
Signature	**Signature**
_____	**Patrick Finnerty – Director**
Name and Title	**Name and Title**
_____	_____
Date	**Date**

ATTACHMENT XXV – MMIS GENERATED PAYMENT
XXX MCO

		Region				
Aid Category	**Age Group**	**Northern Virginia**	**Other MSA**	**Richmond/ Charlottesville**	**Rural**	**Tidewater**
Aged, Blind / Disabled	Under 1 1-5 6-14 Female 15-20 Female 21-44 Male 15-20 Male 21-44 Over 44					
Temporary Assistance to Needy Families	Under 1 1-5 6-14 Female 15-20 Female 21-44 Male 15-20 Male 21-44 Over 44					

Note: Aged category applies only to the 'Over 44' group

ATTACHMENT XXV.I - CAPITATION RATES WITH CDPS ADJUSTMENTS
XXX MCO

		Region				
Aid Category	**Age Group**	**Northern Virginia**	**Other MSA**	**Richmond/ Charlottesville**	**Rural**	**Tidewater**
Aged, Blind / Disabled	Under 1					
	1-5					
	6-14					
	Female 15-20					
	Female 21-44					
	Male 15-20					
	Male 21-44					
	Over 44					
Temporary Assistance	Under 1					
to Needy Families	1-5					
	6-14					
	Female 15-20					
	Female 21-44					
	Male 15-20					
	Male 21-44					
	Over 44					

Note: Aged category applies only to the 'Over 44' group

ATTACHMENT XXV.II – DIFFERENTIAL PAYMENT
Difference in XXX MCO Capitation Rates with CDPS Adjustments and the MMIS Generated Payment

		Region				
Aid Category	**Age Group**	**Northern Virginia**	**Other MSA**	**Richmond/ Charlottesville**	**Rural**	**Tidewater**
Aged, Blind / Disabled	Under 1					
	1-5					
	6-14					
	Female 15-20					
	Female 21-44					
	Male 15-20					
	Male 21-44					
	Over 44					
Temporary Assistance	Under 1					
to Needy Families	1-5					
	6-14					
	Female 15-20					
	Female 21-44					
	Male 15-20					
	Male 21-44					
	Over 44					

Note: Aged category applies only to the 'Over 44' group

ATTACHMENT XXV.II – MCO SPECIFIC CONTRACT TERMS CONTINUED

ATTACHMENT XXV.II. – MCO SPECIFIC CONTRACT TERMS CONTINUED